			1 - For State Registrar	State of M	aryland /		tment of H		nd Mer		jiene	009	26001
			Decedent's Name (First, Middle, La	ist)	-	00717			2.	Date of Dea	th		3. Time of Death
	Physici		CHAPLES	WINKE	ER.					Month Augus	Day	1 2009	510 PM
Jan.	/Medio		4a. Facility Name (If not institution, gire			4	b. City, Town, or	r Location of I	Death	nogos		ounty of Death	
			Good Samaritan	Nursing	Cente	(	Ral+imor	e City	,		Ra	ltimore	City
	Funeral		5. Social Security Number 6.	Sex 749	e (In yrs. last b	oirthday)	Baltimor    Underlyear     Months   Days			Date of Birth (Month, Day			lace (State or Foreign
	Director		3 67 - 36 - 363	1 <b>X</b> M 2□F	93	Yrs.	Months Days	riouis		ar. 18	,1916	6 Mar	ÿĺand
7	* and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wa or Locat	tion						0d. Inside City Limits
a la contra	ohe a	5	Maryland Baltimo	re	100. 0.19, 10	Will of Look		Ltimore	e Cour	ntv			1 ☐ Yes 2X No
4	28a-	ect	10e. Street and Number		1		10f. Zip Code				On Citiza	n of What Cou	atov?
19	n or	Funeral Director	2833 Ontario Aven					21234		'	USA	TO WINE COU	y:
died	18 23 18 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa			n? (Specify	Yes or No-		. Race - Amen	an Indian.
0	5 4	표	1 ☐ Never Married 2 ☐ Married	Armed Forces?	Ng 7004		s Decedent of H es, specify Cuba	an, Mexican, I	Puerto Rica	an, etc.)		Black, White,	
ğ	2 1	þ	3√Widowed 4 □ Divorced	If Yes, Give Year or Dates:	~1934 -	1 [	Yes 2XXXVio	Specify:			S	pecify: Whi	te
	ial Hygiene. d other than "natural", or items 23a or 28a-f ahow avent, the Modical Examiner must be motified at	Completed	15. Decedent's E (Specify only highest gr	ducation	2~1954	a. Deceden	nt's Usual Occup	ation	of working		16b. Kind	of Business/In	dustry
2	en en	nple	Elementary/Secondary (0-12)	Cotlege (1-4or		life. DO	NOT use retired	1)					
2	ygien t,	S	8th grade	N/A		Chief	Petty C				Navy		
Maryland 21215-0036	and Menta Hygiene. Is most set to theme 23s or 28s-1 show aumatic avent, the Modical Examiner must be multiled at	Be	17. Father's Name (First, Middle, Last					18. Mother's	s Name (Fi	irst, Middle, I	Maiden Su	umame)	
aryla	t of Heelth and Men If item 27 is marke or other traumatic	ဥ	Charles William W							May W			
Var	le n		19a. Informant's Name/Relationship		1	_	Address (Street						
	of Heelth If itam 27 or other tr		Deborah W. Healy 20a. Method of Disposition	(Daughter)			est Lanv	are St	Date			tion - City or To	
Mor	9 = 9		XXBurial 2 Cremation 3		cemet	tery, cremat	tory or other place	1 -					
	rtant		4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice		Parki		Cemetery		-15-20	509	Dart.	illore,	Maryland
Balt	Department Important: I eny Injury o		Planting of Furneral service (100)	88m	$Q_{\perp}$	La	lame and Addres ssahn F I Belai:	uneral	Home Balti	more.	Md.	21236	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	0.0	not enter t	the mode of dyin	g, such as ca	ardiac or re	spiratory arr	est,	,	Approximate Interval Between
P	hysician	5 1	Immediate Cause (Final disease or condition	ENG	deta	68	Alza	heime	1'5	1) PM	1en	tia	Onset and Death
	Medical		resulting in death)	Due to (or as	a consequence	e ol):	,,,,			0			
	xaminer	.	Sequentially list conditions,	b									
7	# # #	ne	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	e of):							
acute	and -tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Duo to /or on	a consequence	a all:							
8760,	physicien and the burial-transit			Due 10 (01 as	a consequence	e 01 <i>)</i> .							
The law requires that the death certificate be executed	physis the	dlcal	•	d							-		
X	ettending pl	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						22	d. Date of delive	
Box	etten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		ctopic pregnancy				230	Month	Day Year
o. §	igned by the e	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	t time of doda.	000	(inor (specify)						
בֿ בֿ	ed b	Y P	Part II. Other significant conditions	contributing to death b	out not resulting	in the unde	erlying cause give	en in Part I.		23e. Did tol	bacco use	contribute to t	ne cause of death?
Division of Vital Records,	is n go pir	d by								1 🗆 Y	es 2 🗆 1	No 3 ☐ Prot	pably 4 Winknown
O S	s been should	Completed								24a. Was a	ın i	24b. Were auto	psy findings available
T E	cate hes	mo							-	autops perform	med?	prior to co death?	mptetion of cause of
<u> </u>		0	25. Was case referred to medical					26 Place of	f Death (C	1 ☐ Yes : heck only on	2 No	1 🗆 Yes	2□ No
Veich <	this certifica al director, I	To B	examiner?	Hospital:	ent 2 ERVO	Outpatient	3□ DOA Oth	00				Other (Specif	iv)
VISION OF VITA	er thi		27. Manner of Oeath	28a. Date of Inju	iry 28b	. Time of	28c. Injun Worl			Describe h			7/
	ath. r: After e funer	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation		y rear)	Injury		Yes 2∐No	,				
SIN S	after deat Director: in by the	tfc	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	jury - At home, tc. (Specify)	farm, street	, factory, office		28f.	Location (SI City or Town		Number or Rura	il Route Number,
בֿ בֿ	rs after al Dire ed in by	Certification:		January, C.						o., o o	, oluto)		
Hospital	within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1—Certifying Pl	nysician: To the best miner: On the basis of and manner st	f examination a	ge, death or and/or inves	ocurred at the tin stigation, in my o	ne, date and p pinion, death	place, and occurred a	due to the cat the time, d	ause(s) ar ate and pl	nd manner as s lace, and due to	tated. the cause(s)
Tothe	within 2 To the complet	Me	29b. Signature and title of certifier	and manner su			29c. License	e number		2	9d. Date s	signed (Month,	Day, Year)
•	S - 0		Tenau	_ 6.1.	John	MI	05	857	0		Aug	ast 1	2,2009
10	+1,		30. Name and address of person who	1) / 4	leath (Item 23a	) (Type, Pri	nt)	Roup	el Bi	121	R	Kinor	Day, Year) 2, 2009
V	٧		31. Date liled (Month, Day, Year)	174,00	ar's Signature	ω · (	0001	- 4-6					
	Sta Registr	_	AUG 1 4 2009	Enema &	park	la b							

DHMH 17 Rev 1/2001

09-06299 Gregory Wilson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2009 26002

		For State			(	Certifica	ate of l	Death				Reg. No		00	
Physiciar	1/	<ol> <li>Decedent's Name (First</li> </ol>	Middle,Las	t)						2	. Date of Do Month	eath Day	Year		3. Time of Death
Medical Examin				chony		Donte		Wils			August 1	12, 200	09		0001 hrs
( )	4	4a. Facility Name (if not in Johns Hopkins H		e street and no	umber)			. City, Town, o Baltimore	r Location of	Death		4	c. County of	Death	
Funeral		5. Social Security Number	6. Se	ex	7. Age (In y	yrs. last birth	nday)	If Under 1 Ye	ar If Under	24Hrs.	8. Date of	Birth (MN	//DD/YYYY)		place (State or Foreign
Director		212-25-33	38 X	M 2 F	20	0	Yrs.	Months Da	ys Hours	Min.	03	31	89	Coun	MD
ý	_	Usual Residence of Deced 10a. State 10b. C			100	City, Town	or Location			-		_		<del></del>	10d. Inside City Limits
w an			,		100.	•	Ltime								1 Yes 2 No
Aaryland 28a-f show any 1 at once.	ا دِ	MD	NA			Dal		10f. Zip Code				10a Ci	itizen of Wha		••
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Director	10e. Street and Number	. 7 1		- 4-				217			Tog. C			
vith th		1118 Whit	етось		cedent Ever	in U.S.	13. Was	Decedent of H	.217 ispanic Origi	n? (Spe	cify Yes or	No-		S . A . - America	an Indian, Black,
item	a	1X Never Married 2	Married				if Yes	s, specify Cuba	n, Mexican,	Puerto R	Rican, etc.)		White	, etc.	
fler d		3 Widowed 4	Divorced	If Yes, Give Ye		NO	1 \	res 2X N	o specify:				Specify:	B1c	ack
ours a atura	و ا	15. Decedent's Education	n (Specify o	nly highest gra	ade complete			s Usual Occup- st of working lif				16b	. Kind of Bus	siness/Inc	dustry
6 72 h 3n "n	leted	Elementary/Secondary	(0-12)	College (	1-4 or 5+)	``		-			,,,				
5-0036 iled within 72 hours afte Hygiene. 4 other than "natural", the Medical Examine.	Comple	11th grad 17. Father's Name (First, I	<u>e  </u>	na			Gen	eral L	abore	er	First Middl	NE Maide	C Sta	<u>affi</u>	ing
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Š Be	Andre C.									Rich				
212 212 Jid be Mente mark		19a. Informant's Name/Re				198	o. Mailing .	Address (Str						n, State,	Zip Code)
MD 21 ad 2 should lith and Me m 27 is ma	7	Gloria Wi	llian	ns-Mot	her	[13	118	Whitel	ock s	Stre	eet,	Bal	timo	ce,	Md 21217
e, land Healt Healt item	Ī	20a. Method of Disposition					of Disposit	ion (Name of c	emetery,		Date	200	. Location -	City or T	own, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene, fant: Ifitem 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		1 X Burial 2 Cre		1	rom State			orial	Park	8/1	L <mark>7/</mark> 09		Mood.	lawr	n, Md
Baltimore, MD 2121! permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other transmatic event, i	1	21. Sign ture of Funeral S	ervice Licer	nsee	10 A		22. Na M = 1	me and Addre	ss of Facility	e +					
TE PR M		23a. Parl I. Enter the dise	au.	VW	OVV		1430	OO Wah	ash i	Ave.	Bal	tim	ore,	Md	21215
Physician		23a. Par I. Enter the dise	ase, or comp cause on ea	olica ins that ach line.	caused the d	death. Do no	ot enter the	e mode of dyin	g, such as ca	ardiac or	respiratory	arrest, s	hook, or flea	art	Approximate Interval Between Onset and
/Medical <a href="mailto:kaminer" km2"="" km2<="" th=""><th>4</th><th>mediate Cause (Final o</th><th></th><th>Gunshot V</th><th></th><th></th><th>i</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>Death</th></a>	4	mediate Cause (Final o		Gunshot V			i								Death
Æ	-	or condition resulting in d		Due to (or as	a consequer	nce of):									
	힐	Sequentially list condition if any, leading to immedia	te	Due to (or as	a conseque	nce of):									
	Examiner	cause. Enter Underlying (Disease or injury that init	iated <sup>C.</sup>	Due to (or as	2.0000000000	nce of									
uted d ansit	<u>й</u>	events resulting in death)	Last d.	Due to (or as	a conseque	1100 01).									
ficate be executed g physician and the burial - transit	Physician/Medical	UNPENDED		AMENDED								_			
760, ficate be g physic the bur	ĕŀ	IF FEMALE:			, outcome of	pregnancy			-			12	23d. Date of	delivery	
687 ertific ding p	ian/	23b. Was decedent pregnation past 12 months?	ant in the	D	birth	- f -1 Al-		al death 3	Ectopic	pregnar	псу	T	Month	D	ay Year
Box 68 e death certil the attending	sic	1 Yes 2 No 9	Unknow		nant at time nown	or deadi	5 Oth	er (Specify)							
P.O. Box 687 s that the death certific gned by the attending detached for use as t		Part II. Other significant	conditions			not resultin	g in the ur	nderlying cause	e given in Pa	ırt I.	23e. D	id tobacc	co use contr	ibute to t	the cause of death?
P.O. es that the igned by	ğ										1	Yes 2	<b>✓</b> No 3	Prob	ably 4 Unknown
Cords, P law requires the has been sign.	Completed										24a, W	as an			topsy findings available ompletion of cause of
e law e has ge 2 sh	副								_			erformed	<u>1</u> ?	death?	
tal Reciant The certificate		25. Was case referred to	medical	<del></del>				26.Pla	ce of Death	(Check o		- 2	110	V 10.	3 2 110
Vita hysiciau this cer	o Be	examiner?		Hospital: 1	Inpatient	2 🗸 ER/0	utpatient		Other <sub>4</sub>		g Home 5	Res	idence 6	Other	
ion of Vital Rectending Physician: The eath.  or: After this certificate the funeral director, page	-1	27. Manner of Death	40	28a, Dat	e of Injury	I	Time of In	jury 28c. ir	jury at Work				injury occurr	ed	
on tendir eath.	흵	1 Natural 5	Pending Investigat		th, Day Year) I, 2009	231	6 hrs	1_	Yes 2 ✔	No	Subject s	וטנ			
Division of Vital Records, ra after death.  In or Attending Physician: The law requir rs after death.  In Director: After this certificate has been so the fine the fine of th	Certification:	2 Accident 3 Suicide 6	Could not	28e Pla	ace of Injury	- At home, f	arm, stree	t, factory, office	e building, et						ral Route Number, City
Divi spital or nours after neral Dir	je Je	4 V Homicide	determine	(0,000.)	// Local								) Street, Bal		
	Medical	29a. Certifier (Check only one) 2 ✓ Media	ying Physic al Examine	er:On the basis	s of examina	owledge, de tion and/or	ath occum investigati	ed at the time, on, in my opini	date and pla on, death oc	ace, and curred at	due to the o	cause(s) ate and	and manner place, and c	r as state due to the	ed. e cause(s)
To wit	Mec	29b. Signature and title o		and manner	stated				nse number						nth, Day, Year)
		1//	1	1/1	No.			0.0	C.M.E.			Α	ugust 12,	, 2009	
	Ì	30. Name and address of	person who	completed ca	use of death	(Item 23a)									
171	1	Melissa Brassell		Assistant M			111 P	enn Street,	Baltimore	e, MD	21201				
Sta		31. Date filed (Month, Da	(Year)	C2.1	Registrar's S	ignature	ura	r					-		
Regist	rar	AUG 14	ZUUS	LAUN	was fin	· Jegur	and the second								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 12, 2009 7:30 A F. Watkins Lorraine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Tate House Linthicum If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 20%F 83 214-20-5031 14 1925 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 West McKinsey Road 21146 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Secretary Procter & Gamble 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Moran Annie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lee Watkins, Jr. (Son) 307 Old Country Road Severna Park, Maryland 21146 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Glen Haven Mem. Pk. 08/17/09 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death over oncer ears Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 1∐ Yes 26. Place of Death (Check only one 6 Other (Specify) Hospice Other: 4 Nursing Home 5 Residence Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred Injury

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked or any injury or other traumatic eve Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f shov notified at

"natural", or items 23a or dical Examiner must be

event, the Medical

**Funeral Director** 

Completed by

Be

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John

filed within 72 hours after death with the Maryland Hygiene.

Hygiene. "natural", or items 23a or 28a-f show

the burial-transi After within 24 hours after death. To the Funeral Director: the filled in by

Examiner Physician/Medical ò Be Completed Certification: To

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Medical ( 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) an 305 Hospital Dr. Chen Sumie, MD. 21061

D39505

29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) AUG 1 4 2009

dhish

32 Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 2009

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		1 - For State Registrar	Certificate of Death	Reg. N	lo.
	sician edical			2. Date of Death Month B/09/20	year 09 3. Time of Death
	miner	A # 20 A1 (45 A1 19 A)	4b. City, Town, or Location of Death Charlotte Hall	1 4	c. County of Death St. Marys
Fune Direc		5. Social Security Number 226–30–7469 6. Sex M 2□ F 83	irthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 06/15/192	9. Birthplace (State or Foreign Country)  VA
e Maryland	Director	1.00	vn or Location pllywood		10d. Inside City Limits 12 Yes 2 □ No
th with th	at Dire		10f. Zip Code 20636	-	Citizen of What Country? USA
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "fatural", or items 23a or 28a-f show any Injury or Anthe Hammain and the than "any Injury or Anthe Hammain and the than "any Injury or Anthe Hammain".	Thy Financial	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert  1 □ Yes 2X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1 <b>215-0</b> Ithin 72 ho nan "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king	Kind of Business/Industry
22 Hed w	غ ا	12 4 CC	omputer Programmer		leral Government
ylanc yuld be fi Mental I arked of	To Be		Estel	ne (First, Middle, Maide Lle Salis	*
e, Maryla  1 and 2 should the Health and Meni em 27 is marken		19a. Informant's Name/Relationship (Type. Print)	b. Mailing Address (Street and Number or Ru 5928 Kimberly Court,		
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours aft partment of Health and Mental Hygiene. partment of Health and Mental Hygiene.	5	4 Donation 3 Done (Specify)	of Disposition (Name of ey, crematory or other place) It Crematory 8/1		Location - City or Town, State Hanover Maryland
Baltimo permit. Pag Department Important: I	once.	21. Signature of Funeral Service Licensee Victor P. Doda	charles L. Stevens 1501 E. Fort Avenue	Funeral Hor	me, Inc. e Maryland 21230
Dhomisi		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physici /Medio Examin	cal	disease or condition resulting in death)  a. Due to (or as a consequence	OF DYSTROPH	£	
	<u>ة</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):		
68760, Ct ificate be executed g physician and ss the burial-transit	Cal Examiner	resulting in death) Last  Due to (or as a consequence	of):		
I Records, P.O. Box 68760, CA. The law requires that the death certificate be executed ate has been signed by the attending physician and sade 2 should be detached for use as the burial-transit	ian/Me		h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P, uires that signed by id be deta	à A	Process To To Contributing to death but not resulting to	in the underlying cause given in Part I.		o use contribute to the cause of death?  2 □ No 3 □ Probably ★★ Unknown
DIVISION OF VITAI RECORDS, I or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be a	Completed	ESSENTIAL MYPERTEN	HOTON	24a. Was an autopsy performed?	
f Vita nysician: nis certific director,	Be (	25. Was case referred to medical		th (Check only one)	
Of Vita Physician: rthis certific	P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/O		ome 5 Residence	
VISION OT Attending Phys r death. ector: After this of	ation	27. Manner of Death 11 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b.	Time of lnjury at Work?  M 28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
DIVISIO  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Sulcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
he Hospi in 24 hour he Funer	edical		e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	e, and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To t within	Ž	29b. Signature and title of confifier , M.D.	29c. License number D67788		8 i 0 2009
<b>d</b>	)	30. Name and address of person who completed cause of death (Item 23a) LEENA RAO KODALI 29449 Cha	and other II-11 p. 1 of		,
	State istrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	arlotte Hall Road, Ch	ariotte Hal	LI Maryland 20622

nen Wheele		1- For State	ate of Maryla		rtment of tificate of		and	Mentai	Hyg		leg. No	20	10	2500
Physicia	an/	negistrar 1. Decedent's Name (First, Middle Carmen W							- 1	Date of Dea	ath Dav	Year	3. Time of	
dical Exami	ner	4a. Facility Name (if not institutio		imber)	14	h City Toy	vn orlo	ocation of De		August 1	1, 20	09 lc. County of De	0725	hrs
		605 Montgomery Street		Siliber)		Laurel	VII, OI LO	00000110120	Cum			Prince Geor		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under		If Under 24		B. Date of Bi	rth(MN	WDD/YYYY) 9. 1964 For		
Director		unkn.	1 M 2 X F	44	Yrs.	Months	Days	Hours	Min.	11/	1 / 1	964	Country)	'A
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on							10d. Insid	e City Limits
ž ,	٦	MD Prin	ce Georg	ge's	La	urel							1 XYe	s 2 No
e Maryla or 28a-f	Director	10e. Street and Number 605 Montgoi	mery Str	reet		10f. Zip C	<sup>ode</sup> 207	07			10g. C	itizen of What C	ountry? JSA	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 1 Never Married 2 Ma	12. Was De	cedent Ever in U.:				anic Origin? Mexican, Pu			0-	14. Race - Am White, etc		Black,
	by Fur	3 Widowed 4 ZDiv	1 Yes orced If Yes, Give Yes or Dates:			Yes 2 X	_					Specify:	White	:
136 hin 72 hours afte e. than "natural", edical Examiner	ted	15. Decedent's Education (Spec Elementary/Secondary (0-12)		de completed) 1-4 or 5+)	16a. Decedent during mo			n (Give kind OO NOT use			16b	. Kind of Busines	ss/Industry	
0036 within 7; iene.	Completed	12				Sec		ary				Auto I	Repair	•
21215-0036  uld be filed within 72 hours after Mental Hygiene.  marked other than "natural", ic event, the Medical Examiner.	Be Co		Strouth	Sr.			18					en Surname) Ckner		
N 2 4 5 5	٩	19a. Informant's Name/Relations Carol D. Str		Mother								City or Town, St		
		20a. Method of Disposition  1 Burial 2 XCremation	3 Removal f	rom State	Place of Disposi rematory or oth	er place)				oate 8/2009		. Location - City Hanove		e
Baltimore permit Pages 1 Department of 1 Important: If injury or other		4 Donation 5 Other Sc 21. Signature of Funeral Service			211 22 N	ame and A	idress o	f Facility			1			
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		Do not enter th	e mode of	dying, sı	uch as cardi	iac or re	espiratory ar	теst, s	hock, or heart	Approxi Betwee	mate Interval n Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)		osclerot a consequence of		iovas	cul.	ar dis	seas	se			-	Death
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e be executed ysician and burial - transit	edical E	X UNPENDED	d. AMENDED	23a,27,	per ME	g894	8/	19/09	TT					
760, icate be exphysician the burial		IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregi	nancy						2	23d. Date of deli	•	
Box 6876 e death certificate the attending phy ed for use as the b	Physician/N	past 12 months?	LILIVE	birth nant at time of de	ath -	al death ier <i>(Specif</i> )	3 <u> </u>	Ectopic pr	egnanc	у		Month	Day	Year
Bone death	hysi	1 Yes 2 No 9 V Uni	9 Oliki											
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be rs after death.  al Director: After this certificate has been signed by the attending physicited in by the funeral director, page 2 should be detached for use as the buri	٤	Part II. Other significant condit	ions contributing t	to death but not re	esulting in the u	nderlying c	ause giv	ven in Part I.				No 3	ra-	
ords, P.C w requires that as been signed t should be deta	olete									24a. Was			autopsy findi to completion	
	Completed									1 Yes	ormed 2			2 No
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of Virting Physic	입	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of Ir		^	at Work?				injury occurred	ther: Scene	
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Division lal or Attent rs after death al Director: led in by the	Certification:	3 Suicide 6 Coul		ce of Injury - At ho	ome, farm, stree	t, factory, c	ffice bui	ilding, etc.	28	or Town,		t and Number or	Rural Route	Number, City
Division of Vital with Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Co	29a. Certifier (Check only 1 Certifying Pl	nysician: To the be miner:On the basis	est of my knowledges of examination a										_
To vit	Me	29b. Signature and title of certifie	and manner	stated.		29c. I	icense	number			290	d. Date signed (	Month, Day,Y	ear)
,		high	no +-			(	O.C.M	I.E.			Aı	ugust 11, 20	09	
\$		30. Name and address of person Ling Li, MD Assista	who completed cau		<sup>23a)</sup> Penn Stree	t, Baltim	ore, N	1D 21201		-				
	ate	31. Date filed (Month, Day, Year)	32. R	Registrar's Signatu	re barks	/								<u> </u>
Regist	ueli	AUG 1 2 AU	To port	- /-			_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 Month **Physician** Mayaline Wallace 3:58 р м July 31, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Lorien Columbia Health Care Center Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 7. Age (In yrs. last birthday) 98 vrs 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year, 9-22-1910 1 ☐ M 2 🛛 F Georgia **Director** 021-30-7101 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event. If a Modical Examinal must be notified at once. Columbia 1X Yes 2 □ No Maryland Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 6334 Cedar Lane Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public School System Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julia Aline Belcher J.W. Jamerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7325 Brookview Road #302 Elkridge, Maryland 21075 Laura A. Covington (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State %Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Cemetery 8-11-2009 SIlver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, INc. 21. Signature of Funeral Service Licensee marshall 4217 9th Street, N.W. Washington, D.C. MOGT 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician Coronary Artery Disease years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dementia years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No fοr Month Day Year 5 Other (specify) ned by the a signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No Hospitel or Attending Physiclen: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours af To the Funerel D completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified ND D0053150 08/05/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Shakunmala Gupta

31. Date filed (Month

AUG 14

MD

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

9650 Santiago Road Suite 110 Columbia, MD 21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** enal Aug ust 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner N/A If Under 1 Yea 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) **Funeral** Hours LABUN as Bernard L. Wilson, J. 1**½** M 2□ F Months Davs 45 219-90-7419 12/28/64 MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at N/A MD Baltimore 1 XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 230 Earhart Court 21117 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit, Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten eny injury or other traumatic event, the Medical Examine once. Black White etc. African 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐XO Specify. þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard L. Wilson, Sr. Frances Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Carter/Cousin 230 Earhart Court, Owings Mills, MD 21117 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/14/09 Ardent Crematory Hanover, MD 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of FacilitHari P. Close F.S, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** AD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.

821

AUG

A. AHMED

31. Date filed (Month, Day, Year)

Eulau

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year August 9, 2:14 P M Monroe L. Wright 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death A/NGift of Hope Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/06/1930 9. Birthplace (State or Foreign 5. Social Security Number Sex XXM 2□ F 7. Age (In yrs. last birthday) Days Min. Hours Maryland 78 214-26-0098 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 ☐ No Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21205 818 N. Collington Avenue 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2 🕱 No Black Specify 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employes Meat Distributor 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Milborn Edward Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5119 Donovan Drive Alexandria, Virginia 22304 Leslie Wright - Niece 20b. Place of Disposition (Name of Cemetery, crematory or other alace)
Arbutus Memorial
Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 08/13/2009 Arbutus, Maryland 4 □ Donation 5 □ Other (Specify) David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licensee 23a. Part Finter the disease, or complete ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) (ana. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter this right of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1∐ Yes 2,⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760. signed by the a d be detached f P.0. Records. icate has been si certificate Division of Vital director, this ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti After 1

Examine Physician/Medical þ Completed Be Certification: To funeral c

**Physician** 

Examiner

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

should be filed within 72 hours after death with nd Mental Hygiene.

marked other than "natural", or items 23a or

12 should be fill h and Mental F ' is marked otl

permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is n any injury or other traur

**Physician** /Medical

Maryland 21215-0036

Baltimore,

/Medical

Director

Funeral

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Completed

Be

completely filled in by the Medical

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

Druse Praybuand manner stated.

5 Pending investigation

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Balk MD

he mulithur MS CRNP

R072811

29c. License number

29d. Date signed (Month, Day, Year) 8-10-09

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. Arthur 600 N. Wolfest.

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

To the within 2

# ■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		1. Decedent's Name (First, Middle	le, Last)					2. Date of				3. Time of Death
Physicia /Medic		Cesar A. Alva						July	Da 2		Year 109	7:05 A M
Examin		4a. Facility Name (If not institution	n, give street and number)	)		4b. City, Town, or	Location of Death	July		. County of		7.03.A
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Funeral		5. Social Security Number	I differ all a		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Month.	Birth Day, Year)		9. Birthp	lace (State or Foreign
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and		10a. State 10b. County	,	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
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should be filed within 72 hours after death with the Maryland and Mental Hygiene.  s marked other than "natural", or items 23a or 28a-f show umatic event, It a "to fice! Examine" in the notified at	Funeral Director	1419 Ashton Roa	d			200	<i>c</i> 1			US		
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ours	d by	3 ☐ Widowed 4 🛱 Divorced	If Yes, Give Year or Dates:			I∐Yes 2€No	Specify:			Specify:	Asi	an
72 h	Completed	15. Deceden (Specify only highe	nt's Education est grade completed)		16a. Deced	dent's Usual Occupa	ation during most of work	ina	16b. K	ind of Busi	iness/Ind	dustry
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ntal hed of	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nam			Surname,	)	
d Me	၉	Simeon Alva					Felisa <i>F</i>					
and 2 sleath an m 27 is i		19a. Informant's Name/Relations Nimfa Arellano/				ig Address (Street &				,	. ,	,
1 an Heal Heal	-	20a. Method of Disposition	Daughter	20b. Pi		ilestone		<u>rer Spr</u> Date		MD. ocation - C		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination into the multiled at once.		1 🕅 Burial 2 ☐ Cremation				sition (Name of natory or other place						
artme		4 ☐ Donation 5 ☐ Other (S		5τ.	Peter	's Cemete	ery Augus	<u>t 1, 2</u>	<u>009 h</u>	<u>la 1do</u> r	cf,	Maryland
permit. Depart Import any Inj		V 00.	I A I IA	mii a	XX 30	. Name and Addres	ochinator	itt fur	iera I	Home	MD	00501
		23a. P. 11. Enter the disease, or	r complic W ns that caused	the death	Do not ente	035 Old Wa	a Such as cardiac	or respirator	Wa I do	ort,	Мυ	ZU6U1 Approximate
Di		shock, or heart failure. List Immediate Cause (Final	only one cause on each III	ne.		or the mode of dynn	g, sacri as cardiac	or respiratory	arrest,			Interval Between Onset and Death
Physician //Medical		disease or condition resulting in death)		mei	1							Months
Examiner			Due to (or as	a consequ	ence ot):							on other
	ē	Sequentially list conditions, if any leading to immediate	b. Due to (or as	a conse	ence of						Y	NONTHIS.
cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
be executed cian and ourial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):							
	ca		d									
rtifica ng ph as th	Physician/Medica		1	-					Т			
attendin for use	Jug	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,			23d. Date	of delive	ery
ne dea the at hed fo	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a			Other (specify)			-	Mont	th	Day Year
at the	h	9 Unknown										
	ò	Part II. Other significant condition	ons contributing to death b	ut not resu	Iting in the un	nderlying cause give	en in Part I.	23e. Di	d tobacco	use contrib	oute to th	ne cause of death?
w requires to been signal should be								1[	]Yes 2	™No 3	B ☐ Prob	oably 4 🗌 Unknown
e law r has b	Completed							24a. Wa	as an topsy	24b. W	ere auto	psy findings available mpletion of cause of
The ate by page	Š							pe	rformed?	de	ath?	2 No
sician; The la certificate ha rector, page 2	Be (	25. Was case referred to medical examiner?					26. Place of Deat					
hysk this c		1 Yes 2 No			ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 🖫 Re	esidence	6 ☐Other	(Specif	y)
ing P	Certification: To	27. Manner of Death  1 Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Time of Injury	28c. Injury Work	/ at ?	28d. Describ	e how inju	ry occurred	d	
tend leath. for: /	cati	2 Accident investig	gation			M 1 🗆 1	Yes 2□No		_			
or At fler d direct in by	<b>E</b>	4 Homicide determ		ury - At hor c. <i>(Specify</i>	me, farm, stre ')	eet, factory, office			(Street ar		or Rura	il Route Number,
urs a		20.0.11	11/2									
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to the funeral director, the funeral director is the funeral director.	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis o	of examinat	vledge, death ion and/or in\	n occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to t red at the tim	he cause(s le, date an	s) and man d place, ar	ner as s nd due to	stated. the cause(s)
ithin of the or the ormple	Mec	29b. Signature and title of certifie	and manner sta	ated.		29c License	number		204 Do	to signed	Month	Day Your
6484		290. Signature and the or certifier	Baters M	U.D	_	Zoo. Liberise	ヘルゴマ	,	29u. Da	Jagried (	120	Day, Year)
	-					ופת	UQTO		1	128	120	207
RI		30. Name and address of person	who completed cause of d	leath (Item	23a) (Type, F	12 m. /	and.	Chu th	1501	100	10	gaarel
Stat	e	31. Date filed (Month, Day, Year)	32. Régistr	ar's Signat	. <i>D</i> .	i= Herry	mulanin	e unes	UUTIL	NOP	rayo	nojoy
Registra		JUL 3	1 2009 Sener	u ,	B. 4	29c. License DS 12 Jan A					•	,

		For State Registrar	State of	of Marylar		rtment <i>tificate</i>		ealth and N Death		giene Reg. No. 🛛 🤈	nno	25010
Physic		1. Decedent's Name (First, Middle, Helen J. Alexar	,						2. Date of Dea Month July 24	Day	Year	3. Time of Death 8:10 PM
/Medi Examir		4a. Facility Name (If not institution,  Crofton Care & F  5. Social Security Number	Rehab Cer		last birthday)	Cro	ofto 1 Year	If Under 24 Hrs.	8 Date of Birt	4c. Count	e Aru	place (State or Foreign
Director		085-18-4720  Usual Residence of Decedent  10a. State 10b. County	1□ M 2	87	Yrs. ty, Town or Lo		Days	Hours Min.	11/1/19	921		Jersey  10d. Inside City Limits
th the Maryk or 28a-f sho	Director	10e. Street and Number	Arundel		Annap	10f. Zip				10g. Citizen o		•
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ent, the Medical Evandration and the notified at	by Funeral	1255 Cherry Sta	12. Was Dec	cedent Ever in U orces? 21 No ive		Was Deced	ity Cuba	spanic Origin? (S n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ace - Ameri ack, White,	can Indian,
21215-0036  within 72 hours aft giene. er than "natural", or the Medical Everying.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed	) (1-4or 5+)	1 (Give	DO NOT us	k done a	luring most of wor	king	16b. Kind of		ndustry
Maryland 2 td 2 should be filed lith and Mental Hyg 7 is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, L William Whyte	ast)					18. Mother's Nan Helen M	cEntee			
e, Mary t and 2 shot Health and t tem 27 is ma other trauma		19a. Informant's Name/Relationsh Allan Alexande:			1255	Cherr	y St		e, Anna		Mary1	and 21403
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at any ongoe.		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation □ Other (Sp. 21. Signatur of Fundaments)	ecity	n State		mator 2. Name an	<b>y</b> d Addres		orge P.	Edgewa Kalas	ter, Funer	Maryland al Home
Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List imme late Cause (Final disease or condition resulting in death)	only one cause on	each line.	th. Do not en	ter the mod	e of dyin		or respiratory a	rrest,		Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	o (or as a conse	quence of): SCU			TION				years years
Box 6 death certifi e attending I d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	1 🔲 Liv	utcome of pregree birth 2 Peregrant at time of	tal death 3	☐ Ectopic p ☐ Other (sp		у			Date of deli	very Day Year
ords, P.O requires that the peen signed by the hould be detached.	by	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	inderlying c	ause giv	en in Part I.		tobacco use co		the cause of death?
Rec The law ate has b	Completed								1 □ Yes	psy ormed? 2 No	b. Were au prior to death? 1 ☐ Yes	topsy findings available completion of cause of
f Vita ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 █ No	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 🗆 DC	Oth	er: 4 A Nursing I	ath <i>(Check only</i> Home 5 ☐ Res		Other (Spec	cify)
on of ding Phys h. After this funeral di	on: To	27. Manner of Death	/6.4	te of Injury onth, Day, Year)	28b. Time of	of 2	28c. Injur Wor	y at		how injury occ		
Division of Vita I or Attending Physician: after death.  Director: After this certification by the funeral director.	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Pla	 ce of Injury - At Iding, etc. <i>(Spe</i> c	home, farm, st	M reet, factory		Yes 2 □ No	28f. Location City or To	(Street and Nu wn, State)	mber or Ru	ıral Route Number,
Hospita 4 hours Funeral tely fille	edical	29a. Certifier 1 Certifyir (Check only one) Medical	g Physician: To t Examiner: On the and ma	he best of my ki basis of exami anner stated.	nowledge, dea nation and/or i	nvestigation	n, in my o	opinion, death occ	e, and due to the urred at the time	, date and plac	e, and due	to the cause(s)
To the I within 2 To the Comple	Σ	29b. Signature and title of certifie	shov		MI			2010	8	29d. Date sig	26 / C	09
MALE		Rakesh Arora,					te 2	22, Bowi	e, Mary	1and 20	715	
S	tate	31. Date filed (Month, Day, Year)		Registrar's Sign		4. 4						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Physician Jocelvn Allison Abraham 27, 9:10 a July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Montgomery 9708 Lorain Avenue 8. Date of Birth
(Month, Day, Year)
April 27, 1940 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Funeral Days Min 578-76-8771 1 ☐ M 2 🔀 F 69 Trinidad Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 3 any injury or other traumatic event, the Mexical Examina Erra any injury or other traumatic event, the Mexical Examina Erra and 2008. 9708 Lorain Avenue 20901 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married I∐Yes 2. XINo Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes. Give Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Assistant School 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David O'Neil Daphine David ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9708 Lorain Avenue, Silver Spring, MD 20901 Randolph A. Abraham/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Aug. 3 2009 1XXBurial 2 □ Cremation / 3 □ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation /5 ☐ Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Fur eral Service Vix nsee 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 months Diffuse Large B Cell Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Ve the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Completed Be Certification: To

Division of Vital Records, P.O. Box 68760,

									1∐ Yes 2L	4No 3□ Probably 4□ Unknown
					_				24a. Was an autopsy performed? 1 □Yes 2X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case refer	red to medical					2	6. Place of Dea	th (C	Check only one)	
examiner? 1 ☐ Yes 2 至	No	Hospital:	1   Inpatient 2	ER/Outpatient	3□1	Other:	4 ☐ Nursing H	lome	5 Residence 6	Other (Specify)
27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	h 5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury a Work? 1 □ Ye	t s 2 □No	280	d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - At he building, etc. (Special	ome, farm, stree	t, facto	ory, office		28f	Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only	XXCertifying Ph	ysician: on	To the best of my kno the basis of examina	owledge, death o	occurre	ed at the time on, in my opir	, date and place nion, death occu	e, an	d due to the cause(s) at the time, date and	and manner as stated. place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number D0068056 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth Pfaffenroth, 1221 Mercantile Lane, Largo, MD 20774 MD

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 31 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amendate of Marylarker Department of Realth and Wental Hygiene

		A For State Registrar	megdate of p	Marylane/Deb Ce	ariment of			iene g. No. 009	26012
		1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat		3. Time of Death
Physici /Medio		Richard Allen Art	ice				July 29	, 2009	2:30 F M
Examir		4a. Facility Name (If not institution, git Dennett Road Mand			4b. City, Town	n, or Location of Dea 1d	ath	4c. County of D	
Funeral Director		215-36-7692	Sex 7. 1 <b>X</b> M 2 □ F	Age (In yrs. last birthday 72 Yrs.	Months Day			, 1937 Ma	Birthplace (State or Foreigr Country) aryland
ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
e Ma	Director	MD Garret	<u> </u>	Friendsv					
or 2	Dire	10e. Street and Number			10f. Zip Cod 21531		יו	0g. Citizen of What USA	Country?
s 23s	rai	950 Old River Ro	12. Was Decede	et Fueria II S 12		of Hispanic Origin? (	Specify Ves or No.		merican Indian,
within 72 hours after death with the Maryland jiene. jiene. then *naturel*, or Items 23e or 28e-f show the Maylical Examiliar must be molified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced	Armed Force  1 Yes 2  If Yes, Give  Year or Date	os? <b>X</b> No	If Yes, specify O	uban, Mexican, Pue	into Rican, etc.)		/hite, etc. White
of 2 should be filed within 72 hours aft th and Mental Hygiene. Z7 is marked other than "natural", or traumatic event, I'le Maulcal Exami	Completed	15. Decedent's E (Specify only highest gi	ade completed)	(Give	edent's Usual Oc e kind of work do DO NOT use rei	ne during most of w		16b. Kind of Busine	
d within giene. r than	mo:	6	College (1-4		erman			Timber	
be filed tal Hygi d other	0	17. Father's Name (First, Middle, Las	t)			18. Mother's N	ame (First, Middle, M	Maiden Sumame)	
Vid by Aenta	TOE	Charles Richard	Artice			Elsie N	Mae Coddin	gton	2000 1010
2 should be in and Mental I is marked o		19a. Informant's Name/Relationship					Rural Route Number		e, Zip Code)
and and mag		Ethel I. Artice/	Wife				sville, MI		
oermit. Pages 1 an Department of Heal mportant: If item 2 any injury or other anges.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from Sta	20b. Place of Disp cemetery, cre				20c. Location · City	
Pag ment ant: jury c		* 4 ☐ Donation 5 ☐ Other (Spec		Steele C					
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Fune all Service Lice	elma	/			Newman Fur antsville,		
Physician	Ċ.	23a. Part1. Enter the disease, or co shock, or head failure. List on Immediate Cause (Final disease or condition	nplications that cau y one cause on eac	sed the death. Do not en h line.	_	dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death US
/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	cirona				weaks
cate be executed physician and it the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequence of):					
ficate b physic as the bi	edical		_ d						
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal death 3 It at time of death 5	□Ectopic pregna □ Other (s <i>pecif</i> y			23d. Date of Month	delivery Day Year
uires that signed by ld be deta	by	Part II. Other significant conditions	contributing to deal	th but not resulting in the	underlying cause	given in Part I.			e to the cause of death? Probably 4 Unknow
The law requir sate has been si page 2 should	Completed						24a. Was a autops perform	y prior ned? deat	e autopsy findings availab to completion of cause of h? 2□ No
	a	25. Was case referred to medical				26. Place of D	eath (Check only on		
S S S	To B	examiner? 1 Yes 2 No	Hospital:	atient 2 ER/Outpatie	ent 3 DOA	Other: 4 Nursing	Home 5 Reside	ence 6 Other (	Specify)
Attending Phir death. ector: After th		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Injury 28b. Time Day Year) Injury		njury at Work? 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
of or Attending after death. Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not determine	be 28e. Place of building	Injury · At home, farm, s , etc. <i>(Specify)</i>	treet, factory, offi	ice	28f. Location (Si City or Town		r Rural Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the base and manne	est of my knowledge, dea is of examination and/or i r stated.	ath occurred at the	e time, date and pla ny opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
To the Ho within 24 I	Me	29b. Signature and title of certifier			29c. Lic	ense number	2	9d. Date signed (M	
		30. Name and address of person who	Completed cause	of death (Item 23a) (Type	DO Print)	061801	-	7129	July 29 2009
	3	311 1.484 9	Ty Sai	TR 1, oak 4	and w	0 2159	0		
St: Regist	ate	31. Date filed (Month, Day, Year)	2009 32. Reg	jistrar's Signature	Booked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 07:54 AM 30 2009 /Medical Lorenzo Baker, Jr. July 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 36 Cara Cove Road North East
If Under 1 Year | If Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In vrs. last birthday, 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Min. Months Hours 1 X M 2 □ F 68 Yrs Director Aug. 2, 1940 Virginia 217**–**34**–**6158 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinating and 1 ☐ Yes 2 TNo Director Maryland Cecil North East 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21901 United States 36 Cara Cove Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X'es 2 □ No If Yes, GiveUS Army Year or Dates Reserves Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or 1 ☐ Yes 2/CXNo Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be of Health and Ment item 27 is marked Carson Lorenzo Baker Dorothea Haymore ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36 Cara Cove Road, North East, Maryland 21901 Dorothy J. Baker / Spouse permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 4. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 2009 Baltimore, Maryland Funeral Service Lucensee 22. Name and Address of Facility Crouch Funeral Home 21. Signatus 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami insufficience and as the burial-trar Due to (or as a consequence of) P.O. Box 68760 attending physician certificate be Diabetes Physician/Medical IF FEMALE: nse If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Ye ar 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ obstuctive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown pulmonary Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo

10+ IVA

State Registrar 31. Date filed (Month, Day, Year)

Greenbern

32. Registrar's Signature parts General

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LISE Greenberg MP 9712 Belair Road

Suite 100, Noitingham

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year August 4 2009 Betty Jane BARTON 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Golden Living Center 5. Social Security Number 6. Sex Hagerstown If Under 1 Year | If Under 24 Hrs Washington 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye April 23 9. Birthplace *(State or Foreign Country)*Maryland Hours Year) Months Days 1 □ M 2 K F Í938 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XYes 2 No Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 21740 486 McDowell Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

dical Certification: To Be Completed by Physician/Medical Examiner

Ö	8		Home	maker				Her own	home
Be Con	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle	, Maiden	Surname)	
2	Robert L. Barton				He1	len L. V	ulga	mott	
	19a. Informant's Name/Relationship (7)	ype. Print)	19b. Mailing Addre	ess (Street a	nd Number or R	ural Route Numb	er, City o	or Town, State,	Zip Code)
	Tammy Adcock - Da	ughter	900 W. W	lashin	gton Str	ceet Apt	. 1,	Hagers	town, Md.2174
	20a. Method of Disposition	1 0	lace of Disposition (/	Vame of or other place	9)	Date	20c. Lo	ocation - City or	Town, State
	1 ☐ Burial 2 XCremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		gerstown	Cremai	ory 8/4	./09	Наог	erstown	, Maryland
	21. Signature of Funeral Service Licens			and Addres		Minnich			
	SCATIM	Munus	415 H	E. Wil	son Blvd	l. Hager	stow	n, Mary	land 21740
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ilic rions that caused the death one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	· chroni	obstuli	ii O	uwa	y die	0-20		1044015
	resulting in death)	Due to (or as a consequ	ience o :			0			
	Sequentially list conditions,	b				~			
ner	rially, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (unas a nonsequ	isnos cf):						
ami	that initiated events	c							
Ä	resulting in death) Last	Due to (or as a consequ	uence of):						
<u>ca</u>		d							
Med	IF FEMALE:								
an/	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal	ncy Ideath 3∐Ectopi	c pregnancy				23d. Date of de Month	elivery Day Year
Be Completed by Physician/Medical Examiner	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 ☐ Other	(specify)				WOITH	Day Teal
든	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the underlyin	g cause give	n in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
Š						1920	Yes 2	!□ No 3□ F	Probably 4 Unknown
ece						A . W.	_	1 0.45 114	Language Conference Webbs
du						24a. Was		prior to death?	autopsy findings available completion of cause of
ပ္ပဲ						1□ Yes	2 N		
Be	25. Was case referred to medical examiner?	Hospital		Othe		ath (Check only		-	
ို	TLI Yes 27 LINO		ER/Outpatient 3		4 Lanursing I	Home 5 ☐ Res			ecify)
on:	27. Magner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how inju	iry occurred	
ati	2 Accident investigation 3 Suicide 6 Could not be		M		/es 2 □ No				
ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, tarm, street, fac	tory, office		28f, Location City or To	(Street al own, Stati	nd Number or F e)	Rural Route Number,
Medical Certification: To	29a. Certifier 1 Certifying Phy	ysician: To the best of my kno- niner: On the basis of examina	wledge, death occur	red at the tin	ne, date and place	e, and due to the	e cause(s	s) and manner and place, and de	as stated.
edic	one)	and manner stated.							
>	29b. Signature and title of certifier			29c. License	number		29d. Da	ate signed (Moi	nth, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

SH-1

nue

30. Name and address of person who complet d cause of death (Item 23a) (Type, Print)

368

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State of Maryland / L  State Registrar		tificate of E			eg. No. 🤈	nne	26016
	Dhysisis		1. Decedent's Name (First, Middle, Last)				Date of Dear     Month	Day	Year	3. Time of Death
	Physicia /Medic	al -	Naomi Elizabeth Baxter	T			July 25	1		11:44 P. <sup>M</sup>
į	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Riverda:				nty of Deat	eorge's
. (			6005 East Pine Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last bir)	thday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		g. Birt	hplace (State or Foreign
	Funeral Director	- 1		Yrs.	Months Days	Hours Min.	Oct. 3,	1929		untry) g <b>ini</b> a
	p. ,	- 1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town		otion					10d. Inside City Limits
	arylar show	.								1 □Yes 2 No
	the M	Director	Maryland   Prince George's   River	aare	10f. Zip Code		1	0g. Citizen	of What Co	untry?
	with	٥	6005 East Pine Drive		20737			U.S.A	. •	
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-		Race - Ame Black, White	rican Indian,
326	72 hours after death with the Maryland "natural", or items 23a or 28a-f show citical Examine must be nuithed at	þ	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  Affiled Folces?  1 ☐ Yes, Give Year or Dates:	1	☐Yes 2 No	Specify:	Thours, Go.,			Thite
15-0036	n 72 hou "natura eoical E	Completed	15. Decedent's Education (Specify only highest grade completed)	Deced (Give	ent's Usual Occupa	ution	ina	16b. Kind	of Business/	Industry
		mple.	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done d OO NOT use retired)	i i i i i i i i i i i i i i i i i i i	9	Conit	ol Mi	112
2	filed within Hygiene. other than '		8 C 17. Father's Name (First, Middle, Last)	ash:		18. Mother's Name	e (First, Middle,			IK
and	ev d	Be C	Paul DeMarcus Washington Dalton			Annie M			,	
Maryland 2	d 2 should be th and Menta 7 is marked traumatic ev	욘		. Mailin	g Address (Street a	and Number or Rur	al Route Numbe	r, City or To	wn, State, 2	Zip Code)
Ž	ーモトキ		Sharon Fisher/Daughter 60	05	East Pine	Drive,	Riverdal	Le, Ma	rylan	d 20737
Š	r ite		20a. Method of Disposition  X Burial 2 Cremation 3 Removal from State  20b. Place of cemeter	Dispos	sition (Name of natory or other place	9)	Date	20c. Locat	on - City or	Town, State
Ĕ	Pages ment of l		4 □ Donation 5 □ Other (Specify) Maryla		Veterans	8/3/				Maryland
Baltimore,	permit. Page Department Important: I any Injury o once.	ij	21. Signature of Funeral Service Licensee		. Name and Addres					
a.	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	not ente						Approximate Interval Between Onset and Death 13 days
	/Medical Examiner		Due to (or as a consequence	of):						,
	_xummer	-	Sequentially list conditions, if any learning to form the form to	ruc	tive ful	monary	Disen	بعر		uncertain
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury							
oʻ	e exec an an rial-tra	Exa	that initiated events c.  The sulting in death) Last Due to (or as a consequence of the sulting in death).	of):						
68760	icate be executed physician and the burial-transit	edical	d							
O. Box 6	eath certif attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  1 □ Ves 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)	1		230	. Date of de Month	livery Day Year
<b>.</b>	w requires that the dispersion is been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in				23e. Did to	bacco use	contribute to	the cause of death?
rds	quires nn sign uld be	d by	OR heumatorid Arthritis 354	ste	mie Luz	Me	1 <b>X</b> Y	es 2□l	No 3□P	robably 4 Unknown
Vital Records,	e law rec has bee	Completed	Enthematosus 3 Hypertension	<b>\</b>			24a. Was autop		24b. Were at prior to death?	utopsy findings available completion of cause of
			OF War are referred to medical			OG Plans of David	1 □ Yes	2 200		s 2 □No
	Physiclan: r this certific ral director, I	Be C	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	ıtnatier	ot 3 DOA Othe	26. Place of Deat	ome 5 Resid		Other (Sne	ecify)
ō	ding Phys h. After this funeral dir	n: To	27. Manner of Death 28a. Date of Injury 28b.	Time of			28d. Describe h			
jo	Attendin death. ctor: Af y the fur	atio	2 Accident investigation		M 1 🗆	Yes 2□No				
Division of	or fiter	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	eet, factory, office		28f. Location (5 City or Tov		lumber or R	ural Route Number,
	Hospita Hours Funeral tely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination at and manner stated.	e, deatl	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) ar date and pl	nd manner a ace, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date s	igned (Mon	th, Day, Year)
			Your Stembers		Door	2015		7-29	8-20	09
1	II mi		30. Name and address of person who completed cause of death (Item 23a)			A				e
3	Y IU		Lours Stein Sta, M.D. 6  31. Date filed (Month, Day, Year)  32. Registrar's Signature	492	Lander	er Rd, 1	Landove	h, M	ID 2	0785
	Sta Registr		JUL 29 2009	9	hand !					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:50 AM CHARLES 2009 BECKER JULY 25 /Medical 4c. County of Dear 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE WASHINGTON MEDICAL ANNÉ GLEN BURNIE HRUNDEL 8. Date of Birth (Month, Day, Year)

July 26,1973 f Under 1 Year ige (In yrs. last birthday 35 Yrs. 9. Birtholace (State or Foreign **Funeral** 215-76-5144 Maryland Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items the retified at you jujury or other traumatic event, Item Medical Exaculter must be retified at once. MD Anne Arundel Severna Park 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21146 446 Yorkshire Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Loan Officer Mortgage Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles J. Becker, Jr. Victoria Swan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles J. Becker, Jr./ Father 8390 Piping Rock Court Millersville, MD 21108 July Date 30, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Holy Cross Cemetery Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) Rarranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2. DAYS Physician HYPORIC RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner UNKWON OHKWOH Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 K Probably 4 ☐ Unknown HYPERTENSION, OBESITY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 XYes 2 □ No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After ! 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 2 To the CH 10

Division of Vital Records, P.O. Box 68760,

BECKER, CHARLES J. Baltimore, Maryland 21215-0036

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BOI HOSPITAL DRIVE, GLED BURNIE, HD 20161 ODERO WATO BOOK OMEDIUD

JUL 29

OM: 2301 poisso as consolido

29b. Signature and title of certifier

29c. License number 41 FC 2000 29d. Date signed (Month, Day, Year)

JUCH 52, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Tuc Joseph Α. Biggs Jr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore-Washington Hospital Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Days 1**¥**□ M 2□ F Washington DC 09-01-1936 578-48-6163 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Gambrills Maryland Anne Arundel 1 XYes 2 No 10f. Zip Code 21054 10e. Street and Number 1005 Springhill 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Safeway Elementary/Secondary (0-12) College (1-4or 5+) Selector Food Products 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johnson Biggs Joseph Α. Biggs Jenny 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Tanner 10509 Deakins Hall Dr. Adelphi, Md.20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 7/29/2009 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee Anite 16000 Annapolis Road, Bowie, Md. 20715 M00544 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Renal Immediate Cause (Final disease or condition resulting in death) tallwe Due to (or as a consequence of) 515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 0 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗆 Yes 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: Physician

/Medical

Examiner

**Funeral** 

**Director** 

show

Director

Funeral

≥

Completed

Be

ပ

Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Evand in it is used to such the angere.

**Physician** /Medical

Examiner

burial-transi and

attending physician for use as the buria

signed by the a

has

certificate

death with the Maryland

Biggs Joseph

Maryland 21215-0036

Baltimore,

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital within 24 hours a To the Funeral D

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Joseph La Drive, Gen Burne, 2061

32. Registrar's Signature

**JUL 29** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4c. County of Death John Robert Conlisk 3:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner A Maryland Health Care trio If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 84 Yrs. 8. Date of Birth 08/20/1924 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Min. MEERizgan 386-12-7654 1**X** M 2□ F **Director** Usual Residence of Decedent 10c. City, Town or Location Darlington 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Wedlen Event in the motified at Maryland Harford 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 2111 Shuresville Road 21034 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 1943-45 Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Chemical Engineer 18. Mother's Name (First, Middle, Maiden Surname) Georgetta Koosino 17. Father's Name (First, Middle, Last) William C. Conlisk 19a. Informant's Name/Relationship (Type. Print)

Jane J. Conlisk (wife) 19b. Mailing Address (Street and Number or Pural Floute Number, City or Town, State, Zip Code) 2111 Shwresville Road, Darlington, Marykana 21034 20b. Place of Disposition (Name of cemetery, crematory or other place)

Darlington Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 108-05-2009 Parlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 21. Signature of Funeral Service Vec 123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the durage, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician UKNAM** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate class. Cluse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Nome Knum To Physician: Conlick, John Rober

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

			For State State Registrar	te of Maryland / Depa <i>Cer</i>	artment of Health and rtificate of Death		ene . No. 2 1 1 1 9	26020
	Physicia		1. Decedent's Name (First, Middle, Last) John V. Campbell			2. Date of Death Month 0 1 - 2	Day 9 Year	3. Time of Death
-	/Medic Examin	er	4a. Facility Name (If not institution, give street a 1906 Hibbings Place		4b. City, Town, or Location of Dea Havre de Grace If Under 1 Year If Under 24 Hr		4c. County of Death Harford	lace (State or Foreign
	Funeral Director		5. Social Security Number  214-38-4872  G. Sex 1 🖾 M 2 [ Usual Residence of Decedent	7. Age (In yrs. last birthday) 70 Yrs.	Months Days Hours Mir		138 Maryl	
Section 18 of the section of	23a or 28a-f show ust be notified at	Funeral Director	10a. State 10b. County Maryland Harford 10e. Street and Number 1906 Hibbings Place	10c. City, Town or Lo Havre de G			j. Citizen of What Coun	of America
d 21215-0036	perimit. Tages I amy Should be light within 72 mous aren dean with the liver within the way yan periment if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Modical Eventrical must be notified at once.	Completed by Fune	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Ma	red Forces?  Yes 2 □ No  ss, Give ar or Dates: 1956-59	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue   □ Yes 2 No Specify:  □ Usual Occupation kind of work done during most of work done during most of wood of the specifical in the specific of work done during most of wood of wood of wood of work done during most of wood du	orking	14. Race - Americ Black, White, of Specify: White bb. Kind of Business/Ind	etc. C.C. Justry
land 212	s should be filed with and Mental Hygiene, s marked other that aumatic event, II.C.	To Be Com	Elementary/Segondary (0-12)  17. Father's Name (First, Middle, Last)  Reagan Campbell	Steel Steel	Worker  18. Mother's N Mabel H	ame (First, Middle, Ma	INU (acturin iden Surname)	9
e, S	of Health and M filtem 27 Is mar or other traumat		19a. Informant's Name/Relationship (Type. Print Deanna M. Campbell (M. 20a. Method of Disposition  1 ₺ Burial 2 □ Cremation 3 □ Remova	20b. Place of Dispo	ng Address (Street and Number or Hibbings Place, sition (Name of matory or other place)	Havre de (	Grace, Mary	wn, State
Baltim	Department of I bepartment of I luportant: If its any Injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Strate License	52. Pauc	s Lutheran Cem ( 2. Name and Address of Facility Z 23 S. Washington	elman Fund St. Havre	eral Home, de Grace,	P.A. 21078 Maryland
	hysician /Medical xaminer		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not enter the content of	ter the mode of dying, such as card	lac or respiratory arres	et,	Approximate Interval Between Onset and Death
		dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  Due to (or as a consequence of):			= = =	
O. Box 6	y the attending p ched for use as t	Physician/Med	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P.	s been signed by the should be detached	þ	Part II. Other significant conditions contribution	ng to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to t	
Division of Vital Records,	certificate has bee rector, page 2 shou	Completed	25. Was case referred to medical		OS Place of F	24a. Was an autopsy perform 1 □ Yes 2	prior to co death? No 1 \( \text{Yes}	opsy findings available impletion of cause of 2  No
on of Vi	this ald din	tion: To Be	examiner? 1 ☐ Yes 2 ☐ No Hospita	l: 1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury (Month, Day, Year)   28b. Time of Injury	nt 3 DOA Other: 4 Nursing		nce 6 Other (Speci	fy)
Divisi	within 24 bours after death. Within 24 bours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	3 Suicide 6 Could not be determined 28e	. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town,		
	within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: O	To the best of my knowledge, dea n the basis of examination and/or li d manner stated.	29c. License number	ccurred at the time, da	te and place, and due t	o the cause(s)
	25	1	30. Name and address of person who complete	ed cause of death (Item 23a) (Type	Print) 0/1 /2 ST	BANDA	8/4/2	7/2/4
	Sta		31. Date filed (Month, Day, Year)	32. Registrati's Signature	ball 1	DRMIN	14 ,000	407

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 2009 11:38 A<sup>M</sup> Margaret Alice Calhan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔀 F 535-12-8529 Washington 03/23/1924 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 XNo Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21401 2108 River Crescent Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: White Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Hannity John Ralph Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2108 River Crescent Drive, Annapolis, Maryland 21401 Robert J. Calhan, Sr./Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 07/30/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Funeral ervice 2973 Solomons Island Road, Edgewater, MD 21037 236 Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Imme late Cause (Final disease or condition resulting in death) RESPIRATORY PAILURE MINUTES ACUTE Due to (or as a consequence of) HOURS ASPLIPATION PNEUMONITIS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) PERSISTENT EMESIS Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown DISEASE 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To

/Medical Examiner executed and burial-trar P.O. Box 68760 attending physiclan for use as the buria certificate be as nse sate has been signed by the page 2 should be detached Division of Vital Records,

Physician

Examiner

**Funeral** 

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Exercitor is ust by notified at

within 72 hours after

12 should be filed w h and Mental Hygie 7 is marked other tl

permit. Pages 1 and 2 and 27 is any injury or other trau

**Physician** 

Maryland 21215-0036

Baltimore.

Examiner Physician/Medical Completed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be

1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title

D66753

29d. Date signed (Month, Day, Year) July 27, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arundel Medical Center **2**00**1** Medical Parkway, Annapolis, MD 21401

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 2

32. Redistrar's Signature and

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Nancy Kelley Dowell	State of Maryland / Department of Health and Mo

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State of Maryland / Department of Health and Mental Hygiene	0	0.0		0	,-	0	2	
Certificate of Death Reg. No.	6	UU	9	free	D		4	,

		- For State Registrar	Cer	tificate of	Death			Reg. No	_ < 1	7007 5005
Physiciar edical Examin	1/	Decedent's Name (First, Middle,Last)	well			- "	2. Date of D Month July 19,	eath Day	Year	3. Time of Death 1505 hrs
		4a. Facility Name (if not institution, give street and 861 Bayfront Road	number)	41	o. City, Town, o Lothian	or Location of De	ath		c. County of Anne Arui	
Funeral Director		5. Social Security Number 6. Sex 215-70-9270 1 M 2 X	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Ye Months Da		/lin	Birth(MM 25/19		9. Birthplace (State or Foreign Country) Washington, DC
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State  10b. County  Anne Arundel	10c. City,	Town or Locatio	Lothi	an.				10d. Inside City Limits 1 X Yes 2 No
th the Maryland  23a or 28a-f sho notified at once.	2	10e. Street and Number 259 Main Street			10f. Zip Code 2071	1		10g. Cit		USA
r death wi	Fune			If Ye		lispanic Origin? ( an, Mexican, Pue		No-	14. Race - White, Specify:	American Indian, Black, etc.  White
5-0036 led within 72 hours after the within 72 hours after the material", the Medical Examiner.	eted by	15. Decedent's Education (Specify only highest of		16a. Decedent	s Usual Occup	ation (Give kind fe. DO NOT use		1	Kind of Busi Anne A	ness/Industry rundel
15-0036 Elled within 72 Hygiene. d other than , the Medical	Completed	17. Father's Name (First, Middle, Last)	5+		Teacher		ıme (First, Middi			Public Schools
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	8	Hubert Williams Kelley  19a. Informant's Name/Relationship (Type, Print)	7	T10h Molling	Addross (Sta	Eun:	ice Adk	ison		State, Zip Code)
e, MD 2 1 and 2 shou Health and IN item 27 is n		Barry C. Dowell/Spouse		259 Ma	ain Str	eet, L	othian,	MD 2	20711	
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and Inportant: I tiem 27 is ut injury or other transmit		20a. Method of Disposition  1 Burial 2 X Cremation 3 Remova  4 Donation 5 Other Specify:	l from State	Place of Disposit crematory or othe YVIEW C1	er place) remator	y 7,		) Ba	altimo	city or Town, State
Balt permit. Depart Import injury		21. Signature of Funeral Service Licensee	<i></i>		ame and Addre	ss of Facility Crain <u>H</u> y	Beall Boy. Bo			
Physician /Medical xaminer		23 art I. Enter the disease, or complications the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or a	uries		e mode of dyin	g, such as cardia	ac or respiratory	arrest, sh	nock, or hear	t Approximate Interval Between Onset and Death
	- e	Sequentially list conditions, b.	s a consequence o			_				-
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के हिन्ही.	n/Medical	UNPENDED AMENDE	D			-				
Box 68760, e death certificate be the attending physici ed for use as the buri	Physician/M	23b. Was decedent pregnant in the past 12 months?	es, outcome of preg re birth egnant at time of de known	2 Feta	al death 3 er (Specify)	Ectopic pre	gnancy	2	3d. Date of d Month	lelivery Day Year
P.O. I s that the gned by ti	≥		g to death but not r	esulting in the ur	nderlying cause	e given in Part I.				ute to the cause of death?
cords, law require has been si	Completed						24a. W		24b. W	ere autopsy findings available ior to completion of cause of sath?  Yes 2 No
ital Recipion: The scertificate irector, page	å	25. Was case referred to medical examiner?	Inpatient 2	ER/Outpatient		Other Nu	eck only one)	Resid		Other: Scene
_ = . ^ 2	tion: To	1 Natural 5 Pending Jul 4	ate of Injury onth, Day Year) 0, 2009	28b. Time of In	jury 28c. In	ijury at Work?  Yes 2 • No	28d. Descri	be how ir	njury occurre	
Division ospital or Attendin hours after death.  meral Director: A	Certification:	4 Homicide Could not be determined (Spec	lace of Injury - At h		t, factory, office	e building, etc.			and Number	r or Rural Route Number, City
	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the base and mann-	sis of examination a							
F % F 8	Me	29b. Signature and title of certifier	11/2		- 1	nse number			Date signe	d (Month, Day, Year)
4114		30. Name and a Dress of purson who completed of Pamela E. Southall, MD Assista	ause of death (Item nt Medical Exa	,	Penn Stre	et, Baltimore	e, MD 21201	2 41		
Sta	te		Registrar's Signati							

JUL 27 2009 James S. Janes ORIGINAL

DHMH 17 Rev 1/2001

11:32P M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

pital Dise Glew Burne MO 20061

Year

1 ☐ Yes 2 No

Box 68760 P.O. Division of Vital Records,

neral Director: / within 24 hours a completely

29a. Certifier

(Check only

29b. Signature and title of certifier

040 203 50000 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 per FH G901 3/26/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** leoria 27 1:19 A. JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. So236004444421 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Yrs 263-44-4421 80 Director MAY 17, 1929 WEST VIRGINIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director **VIRGINIA** ARLINGTON ARLINGTON 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? 1606 N. NICHOLAS STREET 22205 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: CAUCASIAN à 3 X Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1 MANAGER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be LEVI H. SHREWSBURY ဂ္ဂ BESSIE P. SNEAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA DUNLAP - DAUGHTER 26 5TH STREET NE, WASHINGTON, D.C. 20002 20b. Place of Disposition (Name of NATTONAT PARK 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State JULY 31.2009 4 ☐ Donation 5 ☐ Other (Specify) FALLS CHURCH, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ARLINGTON FUNERAL HOME CC0412 3901 N. FAIRFAX DR., ARLINGTON.VA 22203 Ya 23a. Part 1. Enter the lifease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart share. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** espiratory disease or condition resulting in death) /Medical Du a to (or as a consa uence of) Examiner Insufficience Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 2 No 2 -100 e Hospital or Attending Physician: 124 hours after death. Funeral Director: After this مصلاتات 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Impatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Tes မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred 1 Vatural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) RES-000 07-27-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adam Kein M.D. T3 283

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death July **Physician** 2009 Dorothy Downing 8:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 202 Cypress Creek Road Severna Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 1, 9. Birthplace (State or Foreign **Funeral** Davs Hours Months New York 1 ☐ M 2 🛛 F 85 069-18-7911 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exandrian must be notified at once. 10a State 10b County Severna Park 1 □Yes 2K No Director MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21146 USA 202 Cypress Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Almeter Julia Becker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severna Park, MD 21146 202 Cypress Creek Road James Downing/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 31, July 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Barranco & Sons, 21. Signature of Juneral Service License Severna Park Funeral Home P.A. Severna Park, MD 21146 495 Gov. Ritchie Hwy. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final yr i Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be execute g physician end is the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical led by the attending prodetached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Atter this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy rmed? 2 ⊟ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature at

CHS

State Registrar Date filed (Month Day, Year) JUL 29 2009

then

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $25^{\text{Day}}$ 2009 1:30 A M July Mabel Donnell 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Annapolis Anne Arundel 201 Admiral Dr. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 257.F 67 Sept. 2.4 1941 212-90-3625 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Nes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Admiral Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 🎉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√€ No Specify: If Yes, Give Year or Dates: Specify: Black 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William s. Simpson Alice M. Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 <u> Venus Bradford (Daughter)</u> Colleen Rd. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Ceme. 7/31/09 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wm. Reese & Sons Mortuary, 821 West St. Annapolis, Md 21. Signature of Funeral Service Licensee Jarry D. Beesenco 48 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on at h line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? -1 ☐ Yes 2 🖪 No 3 ☐ Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important; If item 27 Is marked other I any Injury or other traumatic event, III

**Physician** 

/Medical

Director

Funeral

Be Completed by

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Examiner

**Funeral** 

Director

the

death with

filed within 72 hours after

Maryland 21215-0036

Baltimore,

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

Examiner Physician/Medical ş Completed

Be

27. Manner of Death

and burial-tran the attending physician as for use detached þ signed pe director, page 2 should has this certificate filled in by the funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After 1

Physician; The law requires that the death certificate be executed

68760. Box o ۵.

Division of Vital Records,

State Registrar

Certification: To 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature aj of death (Item 23a) (Type, Print 45, Sell2 4 e and address / per

28c. Injury at Work?

28d. Describe how injury occurred

28b. Time of

28a. Date of Injury (Month, Day, Year)

completely

the within To the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** Harriet D. Estrada July 29, 3:47 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You July 28, 9. Birthplace (State or Foreign **Funeral** Year) 1914 1 □ M 2 🖾 F Months Days Hours 579-40-5137 <sup>Country)</sup> L**ouisiana** 95 **Director** Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 No Oklahoma Tulsa Tulsa 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11114 East 14th Place 74128 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXNo ğ Specify Specify: White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Federal Government h and Mental Hygie permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other transmets 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard B. Dunbar Lena Gardiner ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Estrada/Daughter 11114 East 14th Place, Tulsa, OK 74128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 3, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that cau to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIUS CLEROTIC Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for 1 in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ VALUULAR 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate performe Dementia of Vital 1 □Yes 1 ☐ Yes 2 🗆 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ this 28a. Date of Injury (Month, Day, Year) funeral Certification: 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural ithin 24 hours after death.

5 the Funeral Director: A

5 mpletely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \[
 \begin{align\*} \text{ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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 \begin{align\*} \text{ Medical Examiner: } \text{ On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

 29a, Certifier Medical (Check only one) To the I within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number JULY 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QUEOUSBURY Pd. HYGTTSVIlle MD 20781 DEVORE MD 4203 31. Date filed (Month, Day, Year) 32. Registrar's Signat State 31 2009 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #3610b State Phylaryland 99 epartment and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 200°5 Francis Ellsworth Fletcher 09:10 PMAM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Landover 8609 Dunbar Avenue 8. Date of Birth (Month, Day, Year) 07/19/1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) Days Hours Virginia 1 M 2 F 80 223-30-2106 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count Prince George's 1 ☐ Yes 2 ☐ No Landover Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20785 8609 Dunbar Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛣 No If Yes, Give Year or Dates:1951-53 Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Abigail Tobin John F. Fletcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8609 Dunbar Avenue, Landover, Maryland 20785 Mary Leona Fletcher/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens | 07/24/2009 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of nal S 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's Oyss Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Lectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Tinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 | Yes | ₹ | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide

and burial-trar The law requires that the death certificate be exect P.O. Box 68760, physician the burial attending p as nse ned by the a detached f signed by the Division of Vital Records, has Hospital or Attending Physician: To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

Directo

by Funeral

Completed

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iges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Mories in the modified an

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev

**Physician** /Medical

Examiner

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Physician/Medical

Completed

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Certification:

Medical

29a. Certifier

Baltimore, Maryland 21215-0036

6×1 State Registrar

29c. License number D0050951

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6510, KENILWORTH AVE GILL REVA

RIVERDALE mo.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **JUL 2 4 2009** 



Villiam Fowlkes	State of Maryland / Departme 1- For State Certifica	nt of Health and Mental H <i>te of Death</i>	200	9 25029
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		Reg. No.  2. Date of Death	3. Time of Death
ledical Examiner	William Fowlkes		Month Day Year July 21, 2009	0931 hrs
( Second	4a. Facility Name (if not institution, give street and number) Howard County General Hospital	4c. County of Dea Howard	ath	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	3. 8. Date of 8irth (MM/DD/YYYY) 9. 8 July 14 1940	Birthplace (State or Bign Co <b>Ma</b> )ryland	
	Usual Residence of Decedent			10d. Inside City Limits
ow any	10a. State 10b. County 10c. City, Town or Maryland Anne Arundel Annap			1 X Yes 2 No
Maryland 28a-f show 1 at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	
the Maryland or 28a-f sh tified at once	2040 Parker Dr.	21401	USA	•
	11. Marital Status 12. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? ( S     If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- 14. Race - Am	erican Indian, 8lack,
	1 X Yes 2 No			
rs afte	3 Widowed 4 Divorced If Yes, Give Year 1959-62  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify: ecedent's Usual Occupation (Give kind of		lack s/Industry
72 hou		ring most of working life. DO NOT use ret		
5-0036 ed within 72 houn lygiene "natu other than "natu he Medical Exan Completed		ome Improvement	Self E	mployed
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner To Be Completed by I	17. Father's Name (First, Middle, Last)	18.Mother's Name Amanda	e (First, Middle, Maiden Surname)	
2121 nould be fill and Mental I. is marked tic event, I	Henry Fowlkes  19a. Informant's Name/Relationship (Type, Print)  19b.	Mailing Address (Street and Number or		ate. Zip Code)
MD 21 d 2 should I lth and Mer na 27 is man To			Glen Burnie, Md	
2 % 5 2		Disposition (Name of cemetery, y or other place)	Date 20c. Location - City	or Town, State
MOI Pages ent of int: Il	1 Abdital 2   Olemation 5   Removaliton state		27-09 Crownsv	ille, Md.
Baltimore, permit. Pages 1 ar Department of He Important: If it in important: If it in injury or other the	21. Signature of Funeral Service Licensee	24Whame and to the second Facility Sor		
	Training Rese m 00483  23a. Part I. Eriter the disease, or complications that caused the death. Do not	821 West St. Ar		Approximate Interval
Physician /Medical	failure. List only one cause on each line.		respiratory arrest, shock, or heart	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Due to (or as a consequence of):	IT DISease		
	Sequentially list conditions, b			
iner	if any, leading to immediate cause. Enter Underlying Cause c			1
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·		
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60, tte be execut hysician and e burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	erv
S876 rtifica ling ph	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna		Day Year
D. Box 68760, the death certificate by the attending physiched for use as the burn Physician/Mec	4 Pregnant at time of death 5 Unknown 9 Unknown	Other (Specify)		
<b>2</b> € € € <b>2</b>	Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
rds, P.O. requires that the been signed by thould be detacled by letted by Fletted by Fl			1Yes 2No 3 ✔ P	robably 4 Unknown
of Vital Records, Is g Physician: The law requires ther this certificate has been signeral director, page 2 should be n: To Be Completed				autopsy findings available o completion of cause of
he law ate has age 2 s			performed? death	
	25. Was case referred to medical	26.Place of Death (Check	only one)	
'Nit Physici rthis c al dire	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Out		ng Home 5 Residence 6 Ot	her:
_ = = 1 ° ≈ 1 5	27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Ti	me of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division fal or Attendi rs after death. al Director: / led in by the fi	2 Accident Investigation 28e. Place of Injury - At home, farm	m, street, factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificant completely filled in by the funeral director. Hedical Certification: To Be (	3 Suicide 6 Could not be determined (Specify)		or Town, State)	
8 - 5 > 0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, and	d due to the cause(s) and manner as s	tated.
To the Hosp within 24 hos To the Fune completely fi	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.			
ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (/	Month, Day, Year)
	Willer for for laron locke mi)	U.C.IVI.E.	July 22, 2009	
21	<ol> <li>Name and a ress of person who completed cause of death (Item 23a)</li> <li>Laron Locke MD. Assistant Medical Examiner 111</li> </ol>	Penn Street, Baltimore, MD 212	201	
State	31. Date filed (Month, Day Year) 32 Registrar's Signature	ka del		
Registrar	OUL NI COUS PRIME A.	rever -		

DHMH T/Res through OCME 2006

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1-	For State Registrar	· ·	partment of Health and Certificate of Death	l Mental Hygie	-71164 7 N.H.	30
Physician /Medical	Decedent's Name (First, Middle, Last)  Enid Elizabe			8 2	Day 2009 Year 6 P	eath M
Examiner 4a.	Facility Name (If not institution, give street a	ind number)	4b. City, Town, or Location of De	ath	4c. County of Death	
Funeral 5. S	306 Maryland Av Social Security Number 6. Sex	7. Age (In yrs. last birthda	Westernport  ay) If Under 1 Year   If Under 24 H		Alleg.  9. Birthplace (State or F	oreian
Director	233-50-2812 1 M 2[		Months Days Hours Mi		ar) Country)	
10a	a. State 10b. County	10c. City, Town or	r Location		10d. Inside City	
vith the Mar r or 28a-f sl be notified Director	MD Alleg	Wester	<del>-</del> -		t <b>X</b> □Yes 2	∐No
with the notation of the notat	e. Street and Number  306 Maryland AV		10f. Zip Code	10g.	Citizen of What Country?	
ifter death v r ttems 23a liner must Funeral	Marital Status 12. Wa	as Decedent Ever in U.S. 1	21562  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	USA  14. Race - American Indian,	
urs after or ter examiner	1 Never Married 2 Married 1 If Y	med Forces? ]Yes 2 No 'es, Give\(^\) ar or Dates:	If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☐ No Specify:	érto Rican, etc.)	Black, White, etc.  Specify: White	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at or any injury or other traumatic event, the Medical Examiner must be notified at  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade comp	oleted) 16a. De (G (G life	ocedent's Usual Occupation live kind of work done during most of w e. DO NOT use retired)	yorking 16b	. Kind of Business/Industry	
Com	12		Nurse		Health	
De file oth be file event	Father's Name (First, Middle, Last)			ame (First, Middle, Maid	den Surname)	
Laryland 2 2 should be filled and Mental Hygi sis marked other aumatic event, ti To Be Cc	Dellos Ours  la. Informant's Name/Relationship (Type. Prin	nt) 10b M	ailing Address (Street and Number or	inia Ott	to an Tarres Chata Tip Coda	
and 2 shealth an n 27 is ner traun			5 Maryland Av N			
of Health Filtern 27 and 27 an	Marcy Legge Dauga. Method of Disposition	20b. Place of Dis	sposition (Name of crematory or other place)		Location - City or Town, State	
Pages nent of lury or o	1 ☐ Burial 2 X Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	a nom state		8-3-09 C	resaptown, MD	
Baltimo permit. Pag Department Important: I	Signature of Funeral Service Licensee		22 Name and Address of Equility		uneral Home	
23	Ba. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	s that caused the death. Do not			Approximate Intelval Between	en
Physician Im	imediate Cause (Final sease or condition	lateri celo	to Carel	- VIAC	Onset and De	ath
	sulting in death)	Oue to (or as a consequence of):	1300	- 20-	100	
Service . Ser	equentially list conditions, b.	Oue to (or as a consequence of):				
executed ial-transit Examiner	use. Enter Underlying ause (Disease or injury	nue to (or as a consequence of).				
xecularida res	at initiated events	Oue to (or as a consequence of):				
x 687 entificate ing phys e as the Medic	FEMALE:					
Box 68760, eath certificate be exattending physician for use as the burian cian/Medical Expression in the cian/Medical Expre	b. Was decedent pregnant 23c. If you	es, outcome pf pregnancy Live birth 2 🗆 Fetal death				
. 8 % F   S	1 ☐ Yes 2 🗹 No	Tours of the state	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Ye.	ar
Sh the Sh	9 Unknown	Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			ar
b that the death certificate be set by the attending physicic detached for use as the but y Physician/Medical		Unknown	5 ☐ Other (specify)	23e. Did tobacc		
rrds, P.O. quires that the an signed by the uld be detached	9 ☐ Unknown	Unknown	5 ☐ Other (specify)		Month Day Ye	ith?
requires the requires the signer hould be described by	9 ☐ Unknown	Unknown	5 Other (specify)	10 Yes 24a. Was an	Month Day Ye.	known
The law requires the has been signe bage 2 should be of completed by	9 ☐ Unknown	Unknown	5 Other (specify)	1 Yes	Month Day Ye.  co use contribute to the cause of dea  2 No 3 Probably 4 Uni  24b. Were autopsy findings av. prior to completion of cause	known
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ny Vital Records, hystclan: The law requires this certificate has been signe all director, page 2 should be of To Be Completed by	9 ☐ Unknown  rt II. Other significant conditions contributin  Was case referred to medical examiner?  □ Yes 25000 Hospital	Unknown  ng to death but not resulting in the	e underlying cause given in Part I.  26. Place of Etient 3 DOA	24a. Was an autopsy performed 1 Performed	Month Day Ye.  co use contribute to the cause of dea  2 No 3 Probably 4 Uni  24b. Were autopsy findings av. prior to completion of cause death?  1 Yes 2 No  6 Other (Specify)	known
n or Vital Records, ag Physician: The law requires the this certificate has been signe neral director, page 2 should be of on: To Be Completed by	9 Unknown  The II. Other significant conditions contribution  Was case referred to medical examiner?  I yes 2000  Manner of Death  Manner of Death  Manner of Death  Manner of Death	Unknown  ng to death but not resulting in the	e underlying cause given in Part I.  26. Place of Etient 3 DOA Other: 4 Nursing e of york?	24a. Was an autopsy performed	Month Day Ye.  co use contribute to the cause of dea  2 No 3 Probably 4 Uni  24b. Were autopsy findings av. prior to completion of cause death?  1 Yes 2 No  6 Other (Specify)	known
n or Vital Records, ag Physician: The law requires the this certificate has been signe neral director, page 2 should be of on: To Be Completed by	9 Unknown  The II. Other significant conditions contributing the II. Other significant conditions contributing the III. Other significant conditions contributi	I: 1   Inpatient   2   ER/Outpa	e underlying cause given in Part I.  26. Place of E  tient 3 DOA Other: 4 Nursing e of Work? 1 Yes 2 No	24a. Was an autopsy performed 1 Yes 2 2 2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Month Day Ye.  Double Course contribute to the cause of deal 2 No 3 Probably 4 United Property of Course o	known ailable se of
n or Vital Records, ag Physician: The law requires the this certificate has been signe neral director, page 2 should be of on: To Be Completed by	9 Unknown  The II. Other significant conditions contribution  Was case referred to medical examiner?  1 Yes 2 No Hospital  Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation	I: 1   Inpatient   2   ER/Outpate  Date of Injury (Month, Day Year)   28b. Time	e underlying cause given in Part I.  26. Place of E  tient 3 DOA Other: 4 Nursing e of Work? 1 Yes 2 No	24a. Was an autopsy performed 1 Yes 2 20eath (Check only one)  Home 5 Hesidence 28d. Describe how i	Month Day Ye.  Double Course contribute to the cause of deal 2 No 3 Probably 4 United Property of Course o	known ailable se of
n or Vital Records, ag Physician: The law requires the this certificate has been signe neral director, page 2 should be of on: To Be Completed by	9 Unknown  The II. Other significant conditions contributing the II. Other significant conditions conditions conditions contributing the II. Other significant conditions contributing the II. Other significant conditions contributing the II. Other significant conditions conditions contributing the II. Other significant conditions condit	I: 1 Inpatient 2 ER/Outpa  Date of Injury (Month, Day Year)  Place of injury - At home, farm, building, etc. (Specify)  To the best of my knowledge, di	e underlying cause given in Part I.  26. Place of E  tient 3 DOA Other: 4 Nursing e of Work? 1 Yes 2 No	24a. Was an autopsy performed 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month Day Ye.  co use contribute to the cause of deal 2 No 3 Probably 4 Unit 24b. Were autopsy findings aw prior to completion of caudeath?  No 1 Yes 2 No No e 6 Other (Specify) Injury occurred	known ailable se of
Division or Vital Records, the Hospital or Attending Physician: The law requires the Funeral Director. After this certificate has been signe tipletely filled in by the funeral director, page 2 should be of ledical Certification: To Be Completed by	9 Unknown  The II. Other significant conditions contributing the II. Other significant conditions conditions conditions contributing the II. Other significant conditions contributing the II. Other significant conditions contributing the II. Other significant conditions conditions contributing the II. Other significant conditions condit	It   Inpatient   2   ER/Outpate   2   ER/Outpate   2   ER/Outpate   2   ER/Outpate   2   ER/Outpate   2   2   ER/Outpate   2   2   2   2   2   2   2   2   2	e underlying cause given in Part I.  26. Place of Education and Doal of Part I.  26. Place of Education and Doal of Part I.  26. Place of Education and Doal of Part I.  26. Place of Education and Place I.  27. Viter and Place I.  28. Injury at Work?  1 Yes 2 No  street, factory, office	24a. Was an autopsy performed at the time, date	Month Day Ye.  Double Course contribute to the cause of deal 2 No 3 Probably 4 United Property of the Course of deal 2 Probably 4 United Property of the Course of the Cou	ailable se of
To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be directed.  Medical Certification: To Be Completed by	9 ☐ Unknown  The II. Other significant conditions contributing the II. Other significant conditions contributing the III. Other significant conditions conditions contributing the III. Other significant conditi	Ing to death but not resulting in the last of Injury (Month, Day Year)  Place of injury - At home, farm, building, etc. (Specify)  To the best of my knowledge, don'the basis of examination and/or or anner stated.	e underlying cause given in Part 1.  26. Place of E  titient 3 DOA Other: 4 Nursing e of Work? 1 Yes 2 No street, factory, office  eath occurred at the time, date and pland investigation, in my opinion, death of the period of	24a. Was an autopsy performed at the time, date	Month Day Ye.  Double Course contribute to the cause of deal 2 No 3 Probably 4 United Property of the Course of deal 2 Probably 4 United Property of the Course of the Cou	kth? known ailable se of
To the Hospital or Attending Physician: The law requires twithin 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be done with the funeral completed by Medical Certification: To Be Completed by 30.	9 Unknown  It II. Other significant conditions contributing the conditions con	Ing to death but not resulting in the last of Injury (Month, Day Year)  Place of injury - At home, farm, building, etc. (Specify)  To the best of my knowledge, don'the basis of examination and/or or anner stated.	e underlying cause given in Part I.  26. Place of Education and Doal of Part I.  26. Place of Education and Doal of Part I.  26. Place of Education and Doal of Part I.  26. Place of Education and Place I.  27. Viter and Place I.  28. Injury at Work?  1 Yes 2 No  street, factory, office	24a. Was an autopsy performed at the time, date	Month Day Ye.  co use contribute to the cause of dea  2 No 3 Probably 4 Uni  24b. Were autopsy findings average of the completion of cause death?  1 Yes 2 No  6 Other (Specify)  njury occurred  and Number or Rural Route Number (at and Number or Rural Route Number (at and place, and due to the cause(s)	kth? known ailable se of

		For	State of Ma	ryland /				nd Me	ental Hyg	iene	00	00021
		1 - State Registrar			Ce	rtificate of	Death			eg. No.		20001
Physicia	an	Decedent's Name (First, Middle		-0-1				2	. Date of Death Month	Day	Year	3. Time of Death 2246 PM
/Medic		4a. Facility Name (If not institution		POF		4b. City, Town, o	yr Location of	Death	08	4c Cour	nty of Death	
Examin	er	Gura H Counter in	Manus all OH	han't	1	CaV-	lauc	^			51 V	off
Funeral		5. Social Security Number	6. Sex 7. Age	(Intyrs. last	birthday)	If Under 1 Year Months Days	If Under 2		. Date of Birth (Month, Day,			place (State or Foreig
Director		215-26-8688	18 M 2□F 79		Yrs.	WOTHIS Days	riouis	IVIII I.	June 12	1930		yland
and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
Maryl f sho	to	MD Frede	rick	Nava	Mark	ot						1X Yes 2 □ No
be filed within 72 hours after death with the Maryland ntal Hyglene. By other than "natural", or Items 23a or 28a-f show event, its Medical Examinal must be notified at	Director	10e. Street and Number	TICK	New	Mark	10f. Zip Code			10	0g. Citizen o	f What Cou	ntry?
th with	al D	10215 Coolfont	Crossing			21774				United	l Stat	es
r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13.	Was Decedent of H	lispanic Orig an, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		ace - Ameri lack, White,	
s afte ", or It	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	IfVoc Give			1 □Yes 2 XNo				Spec	ihe	
hour	edk	15. Decedent	Year or Dates:		6a. Dece	dent's Usual Occup	nation		Ţ.	16b. Kind of		ite
s. In "ne	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or 5+		(Give	kind of work done DO NOT use retire	during most	of working				,
d with	Completed	Lichichiary/decondary (0-12)	5+	·′	Rea1	Estate	Agent			Rea1	Estat	:e
be file tal Hy d oth event	Be (	17. Father's Name (First, Middle, L	· ·						First, Middle, N		ame)	
ould I Men narke	ဥ	Henry Allen Gro							a Kunkl			
12 sh thand 7 Isn traun		19a. Informant's Name/Relationsh John A. Groff,		1		ng Address (Street				•		*
1 and Heal tem 2		20a. Method of Disposition	5011	20b. Place		5 Coolfo		Dat		20c. Location		
ages ent of nt: If It		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp				sition (Name of natory or other pla	i	10.120	200	C	ر لـ سم 1 م	MD
permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, I'm Medical Eventione.		21. Signature of Funeral Service L		Cumb		nd Crema	ss of Facility			Cumber		
E E E E		Katherine	Jueitre			David A 21 N. S	. Burd econd	ock I St	Funeral Oaklan	Home,	P.A. 21550	)
		23a. Part 1. Enter the disease, or a shock, or heart failure. List of	complications that cause to	the death. D	o not ent							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	12 0	Zivis	SIM	5 1)	180	i 54	0		,	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	∞nsequenc	e of):							3
	L.	Sequentially list conditions,	b Due to (or as a		0.04).							
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.)	Due to (or as a	consequenc	e or):						12	
execuna and ial-tra	Exal	that initiated events resulting in death) Last	c. Due to (or as a	consequenc	e of):							
icate be executed physician and s the burial-transit	dical		d									
rtifica ng ph as th	Medi	IE ECHAL C										
eath certifii attending p for use as	Physician/Me	IF FEMALÉ: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		ath 3[	Ectopic pregnanc	ev				Date of deliv	
the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of death	1 5 E	Other (specify) _					vlonth	Day Year
that the	Ph	Part II. Other significant condition	ns contributing to death but	not resulting	in the u	nderlying cause giv	en in Part I.		23e, Did tob	acco use co	entribute to t	the cause of death?
uires sign d be	d by	ALZHAIN	mens i	) & a	165	VTIA			1	s 2 No	3□ Pro	bably 4 Onknow
w req	Completed by								24a. Was ar	241	Were auto	opsy findings available
The ta te has age 2	ршо					-			autops perform	y ned?	prior to co death?	empletion of cause of
lan: Triffica	Be	25. Was case referred to medical					26. Place of	of Death (	1 □ Yes 2 Check only one	No No	1 □ Yes	2 🗀 No
hysic lis ce		examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	t 2 TER/	Outpatier	t 3 DOA Oth	or:		5 Reside		ther (Speci	ify)
ng Pl	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,		. Time of Injury	28c. Inju	ry at k?	28	d. Describe ho	w injury occ	urred	
tendi leath. tor: A the fu	cati	2 Accident investigate 3 Suicide 6 Could no	ation of he				Yes 2□N	0				
or At after d Direct in by	Certification: To	4 Homicide determin		y - At home, (Specify)	farm, stre	eet, factory, office		28	f. Location (Str City or Town		nber or Run	al Route Number,
spital ours a leral filled		29a. Certifier 1 ☐ Certifying	g Physician: To the best of	mv knowled	lge death	occurred at the ti	me date and	Inlace an	d due to the ca	ause(s) and	manner as	stated
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		xaminer: On the basis of e	examination								
To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens	se number		29	9d. Date sign	ned (Month,	Day, Year)
		and Pr	my su	24	- /	J Hal	154		1	180	08	1200 4
1510	┍╌┢	30. Name and address of person w	vho completed cause of dea	ath (Item 23a	a) (Type,	Print) /	150	.0-	111	0.1	10	01/20
IVA	5	aul Diniel	Milley	60	1600	17/tax	LSW	1ca	Hame	X V	KY &	71210

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

## 09-06160 Mark Evans Greene

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Registrar	Death	Reg. No. 2000
Physician/	Decedent's Name (First, Middle,Last)	M	pate of Death  3. Time of Death  fonth Day Year
Medical Examine	THE EVALUE OF COME	Au  4b. City, Town, or Location of Death	ugust 6, 2009 2017 hrs
}	4a. Facility Name (if not institution, give street and number) 717 Boundary Avenue	Takoma Park	Montgomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8.	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	226-94-0743 1XM 2F 49 Yrs	Months Days Hours Min.	AUG 16, 1959 Foreign Country) Virginia
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ion	10d. Inside City Limits
. <u>*</u>	Texas Fannin Bonham		1 X Yes 2 No
the Maryland to 28a-f sh lifted at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
- 20		75418	United States
or items 23 must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was 14. Married Armed Forces?	is Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Rica	
er deat	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Yeer	Yes 2 X No specify:	African American
ural" mine	Lor Dates:	it's Usual Occupation (Give kind of work	Specify: done 16b. Kind of Business/Industry
n "nad al Exa	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use retired)	
5-0036 ed within 72 hours a tygiene. other than "natura the Medical Examin Completed by	10 Electi		Construction
15-003 filed withi Hygiene d other th , the Med		· · · · · · · · · · · · · · · · · · ·	st, Middle, Maiden Surname)
21215 Muld be file Mental H marked o c event, ti	and the same of th	Beulah Mae	Route Number, City or Town, State, Zip Code)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umatic event, the Medical			Liver Spring, MD 20910
Ore, M		sition (Name of cemetery, Da	ate 20c. Location - City or Town, State
Fimor Pages nent of lant: If	T Bullar 2 21 Cremation 3 Removal from State	' '	/2009 Glen Burnie, Maryland
Baltimore, I permit. Pages I and Department of Heal Important: If item injury or other tra	21 Signature of Europeal Service Ltd. 22 I	Name and Address of Facility hibadeau Mortuary	
	100000	33 Gist Avenue, LL	. Silver Spring, MD 20910 I
Physician /Medical	23a. Part i. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	ne mode of dying, such as cardiac or res	Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Myocardial fibrosis  Due to (or as a consequence of):		Death
	Sequentially list conditions.		
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
Consider Inside	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
		g895 9/3/09 TT	
760, cate be execu physician and the burial - tra	X UNPENDED AMENDED 23a,27, perME,	8033 373703 11	
		etal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Box 687 death certificate at the attending and for use as the artending and the attending and the attending at the attending	past 12 months?  4 Pregnant at time of death 5 0	ther (Specify)	
J. Bc r the dea	Part II. Other significant conditions contributing to death but not resulting in the	undaylying agues siyan in Part I	23e. Did tobacco use contribute to the cause of death?
P.O res that the signed be detected by I by		andenying cause given in Part I.	1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O tal or stending Physician: The law requires that the start death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaclarification: To Be Completed by F			24a. Was an 24b. Were autopsy findings available
COF e law r e has t ge 2 sh			autopsy prior to completion of cause of death?
tal Rection: The certificate ector, page		26.Place of Death (Check only	1 Yes 2 No 1 Yes 2 No one)
f Vital Physician: pr this certi ral director To Be	examiner?  Hospital: 1 Inpatient 2 ER/Outpatien	I Othor:	
n of ding Ph		Injury 28c. Injury at Work? 28c	d. Describe how injury occurred
ivision or Attend after death. Director: I in by the f	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division o spital or Attending tours after death, neral Director: After filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specific)	et, factory, office building, etc. 28f	f. Location (Street and Number or Rural Route Number, City or Town, State)
lospitz hours unera Unitro			the the cause(a) and manager as about
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certification is the death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician	Certifying Physician: To the best of my knowledge, death occur (Check only 2 Medical Examiner: On the basis of examination and/or investigation)		
F S S S S S S S S S S S S S S S S S S S	and manner stated.  29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)
	D_m _ Imn	O.C.M.E.	August 7, 2009
	30. Name and address of person who completed cause of death (Item 23a)		
		1 Penn Street, Baltimore, MD 2	21201
State Registra	ALICATIONNO 10 . A A.	Ked	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year $\mathsf{A}^\mathsf{M}$ Ruth Gittleson 07 29 2009 9:20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 193-12-3406 Months Days Hours Min. 1 □ M 27 F 86 05-23-1923 PA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5450 Whitley Park Terr.#708 20814 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 🏋 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Helman Dorothy Geller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Gittleson / son 116 Hewlett Neck Rd. Hewlett Neck, NY 11598 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns. 07-31-2009 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityEdward Sagel Funeral Direction, Inc 1091 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death artenosclophe cochouseurs Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical.

Pages 1 jo

permit. Page: Department o Important: If any Injury or ± ŏ

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be ဥ MD

Examiner Completed by Physician/Medical Be Certification: To

the death certificate be executed physician spital or Attending P nours after death. neral Director: After t / filled in by the funera

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Vital

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Division

To the Hospital or within 24 hours at To the Funeral D 20 Registrar

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 10 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗖 📆 🗸 1 🔲 Inpatient 2. ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) rup 55410 07/29/2009

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUL 31 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yevgerny Guchernan, m.p. 8600 ord Ecorge form RCI, Belles da, lup 20814.

32 Registrar's Signature

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		For State Registrar		Stati	e oi ivia	iryianu		artment o			vientai m	ygiene Reg. No	0000	26034
		Decedent's Nam	e (First, Middle	, Last)				imouto c	, Dout		2. Date of D		Y U U D	3. Time of Death
Physicia /Medic		JOSEPH	W. HIN	ES							JULY	25, Da	2009 Year	530 P <sup>M</sup>
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thould nd Me mark matic	2	19a. Informant's Na			)	Г	10b Mailir	na Addraes (Str					or Town, State,	Zin Codo)
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of Hear Item		20a. Method of Dis	position			20b. Plac	ce of Dispo	sition (Name or natory or other	,		Date		ocation - City or	Town, State
Page ment ant: If ury ol			Cremation 5 ☐ Other (Sp		rom State	1	-	KE CREM		7-3	0-2009	ST	EVENSVI	LLE, MD
permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is amy Injury or other trau		21. Signature of Fu	uneral Service L	icensee			22 <b>F</b> )	Name and Ac	dress of Fa	cility ENBET	n & new	MAM	FUNERAL	HOME, P.A.
20260		CHIEF CO.	HN R					200 S.	HARRI	SON S	T. EAST	ON,	MD 2160	1
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Physician /Medical		disease or condition resulting in death)	on	a	e to (or as a	-//	alle							6 months
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Attending ir death. ector: After by the funer	cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could n	ation					I∐Yes 2	□No				
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spital		29a. Certifier	t:⊠-Certifying	Physician: T	o the best o	f my knowle	edge, death	h occurred at th	e time, date	and place	and due to th	ne cause(	s) and manner a	as stated
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	edical	(Check only one)	2☐ Medical E	xaminer: On t	the basis of manner stat	examinatio	n and/or in	vestigation, in r	ny opinion, o	death occu	rred at the time	e, date an	nd place, and du	e to the cause(s)
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		> 11/di	Ulien Lo.		nD				2251			7	1/27/09	
ove		30. Name and addr	ress of person v	vho completed	cause of de	eath (Item 2	3a) (Type,	Print)	East		Mani	land	7/27/09	D 1
Stat	e	31. Date filed (Mon		3	32. Registra		e	1	-001	J. (	( 10/1	,416		/
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	1- State of Maryland / Department of Health and M Certificate of Death	lental Hygiene 009 26035
Physician /Medical	1, Decedent's Name (First, Middle, Last) Ronald James Hall	2. Date of Death O1/31/2009 Year 3. Time of Death 01/00 A M
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace	4c. County of Death Harford
Funeral Director	5. Social Security Number 217-46-2325 6. Sex 1 1 1 M 2 I F 6. Sex 1 N 2 I F 6. Sex 1 Months Days Hours Min.	8. Date of Birth Osar, Year) 9. Birthplace (State or Foreign County) Marykand
Maryland -1 ahow	Usual Residence of Decedent  10a. State  10b. County  Maryland  Harford  Havre de Grace	10d. Inside City Limits 1 ሺ Yes 2 ⊟ No
Maith the same or 28a o	10e. Street and Number 1208 Bern Drive 21078	10g. Citizen of What Country? United States of Americ
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Itame 23s or 28s-4 show other traumatic event, the Medical Examirar must be notified at	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 1 Married  1 Never Married 2 1 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never in U.S. If Yes, specify Cuban, Mexican, Puerto If Yes, Sieve 1 1 Yes 2 No Specify:	ecify Yes or No-Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
215-0 ithin 72 ho he "netur Medical	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12) College (1·4or 5+) 17  College (1·4or 5+)	ing 16b. Kind of Business/Industry  Construction
Maryland 21215-0036 at 2 should be filed within 72 hours att ith and Mantal Hyglene. 27 is marked other than "natural", or traumatic event, the Medical Exami	12 17. Father's Name (First, Middle, Last) Leonard C. Hall Anna Chr	e (First, Middle, Maiden Sumame) istina Roberts
Maryl and 2 shoule eath and Maryl n 27 is mark	19a. Inlormant's Name/Relationship (Type, Print) Anna Hall (Wife)  19b. Mailing Address (Street and Number or Flure 1208 Bern Drive, Havre	al Route Number, City or Town, State, Zig Code) de Grace, Marykand 21078
Baltimore, Moemit. Pages 1 and 2 Department of Health mportant; if item 27 I may july or other trumes.	1 \( \mathbb{Z}\) Burial 2 \( \textstyre{Cremation} \) 3 \( \textstyre{Removal from State} \) 4 \( \mathbb{Donation} \) 5 \( \mathbb{Dother} \) (Specify)  Harford Memorial Gdns 08-04	Date 20c. Location - City or Town, State 4-2009 Aberdeen, Maryland
Baltimor Permit. Pages Department of Important: If the any injury or or once.	21. Signature of Fundral Santo Lice see 122. Name and Address of Facility 123 S. Washington S.	Elman Funeral Home, F.A. t., Havre de Grace, MD 21078
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart feature. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	or respiratory arrest, Approximate Interval Between Onset and Death
58760, ficate be executed in the purision and supplication and supplication in the purision of	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	1 Year
O. Box (in death certified of the death certified for use a metal-fam/M.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Fetal death 3  Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 70 3 Probably 4 Unknown
al Record The law requirements to the second	HYPERTENSION )	24a. Was an autopsy lindings available prior to completion of cause of death?  1   Yes 2   No   Yes 2   No
of Vital F  Of Vital F  Physician: The this certificate ral director, page 17.	25. Was case referred to medical axaminar?	th (Check only one)
3 7 5 SEE 17	Te inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Division of Division of Italian of Attending Parts after death.  Bell Director: After the during the funers	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospi 4 hour Funar Funar		and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
To the within To the complet	29b. Signature and title of certifiers  29c. License number  D40972	29d. Date signed (Month, Day, Year)
335	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ne HAVIACENO MBINO
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Welby Marlyn Hennesy 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep. 26,1913 7. Age (In yrs. last birthday) **Funeral** Days Hours 217-10-9546 95 Director Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 □ No Maryland Washington County Hagerstown Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and injury or other traumatic event, the Medical Examinar must be no once. 21740 922 Armstrong Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Xiyes 2 2 130 If Yes, Give T Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Packing Company Territory Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry J. Hennesy Elizabeth Miller Hennesy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fran Marshall-daughter 1849-B Abbey Lane Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 8-5-2009 | Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Immediate Cause (Final disease or condition resulting in death) **Physician** descare 54 las /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: certificate has been signed by the attendin rector, page 2 should be detached for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ∏ Yes 2 📆 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director Afte completely filler in by the fun 5 Pendina 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Jen J 09

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State Registrar 31. Date filed (Month, Day, Year) AUG 0 4 2009

SHAP 368 mill
32. Registrar's Signature

30. Name and address person who completed cause death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 2:43 PM **Physician** 2009 August 300 L David HIXON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore Of Maryland University Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year Aug. 23, 19 If Under 1 Year | If Under 24 Hrs. 6. Sex 10 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1973 Maryland Director 216-80-9621 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experient must be notified at 1 ☐ Yes 2 📉 o Director Maryland Washington Williamsport 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21795 340 S. Artizan St. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2 XXIII of Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**XX**No *Specify*: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Metallurgy Technician Truck Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wesley Hixon, Sr. Mary Alice Little ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crystal D. Hixon - Wife 340 S. Artizan St. Williamsport, MD 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State injury or Smithsburg Crematory Aug.5,2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Osborne Peneraly Home, P.A. Signature of Euneral Service Licensee 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebral Edema disease or condition resulting in death) /Medical Due to (or as a consequence of): day Examiner Subarachneid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hemorrhad Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and -trar Due to (or as a consequence of) burial the attending physician the dor use as the buriar Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Day Month 5 ☐ Other (specify) signed by the a □Yes 2□No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 21 No has 2 No certificate 1 ☐ Yes 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide I ☑ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AU1476435N18873

State Registrar

NOWAK ZZ S. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BYAN

31. Date filed (Month, Day, Year) AUG 05

MID

ST.

August 3rd

Baltimore,

Soite S-12-D.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of N	Maryland		rtment of F tificate of I	lealth and N Death		giene Reg. No.?	10	26033	
			Decedent's Name (First, Middle,	Last)					Date of Dea     Month	ith Day	Year	3. Time of Death	
н	Physicia /Medic	al	James R. Henn						July	26	2009	10:10 A <sup>M</sup>	
and .	Examin		4a. Facility Name (If not institution,				•	Location of Death		4c. County of Death Anne Arundel			
- <sup>/</sup>			Anne Arundel				If Under 1 Year	Annapolis				INGEL place (State or Foreign	
н	Funeral		,	6. Sex 7. <b>X</b>	Age (In yrs. la 49	a <i>st birtna</i> ay)   Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da	, Year) 3. 1959	Coui	nington,DC	
	Director		219-76-1594 Usual Residence of Decedent		49_				Sept. 1	3, 1939	Wabi	iiiigeoii; be	
	yland now		10a. State 10b. County		10c. City,	, Town or Lo					1	Od. Inside City Limits	
	Mar a-fsi	ctor	Maryland   Anne A	rundel			C	rofton				1 □Yes 2XOXNo	
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V			
	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show deal Evanther must be notified at	ra	2456 Shadywood					1114	acifu Vac or No		U.S.A	can Indian,	
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force 1 ☐ Yes 24	s?	5. 13. 1	f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Blac	k, White,		
36	rs aft	by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 □Yes 2 👿 No	Specify:		Specify	· WI	nite	
21215-0036	2 hou	Be Completed by	15. Decedent	s Education		16a. Dece	dent's Usual Occup	ation during most of work	ring I	16b. Kind of Bu	usiness/In	dustry	
215	hin 7. e. a <b>n "n</b>	ed l	(Specify only highes: Elementary/Secondary (0-12)	College (1-4e	or 5+)	life. l	DO NOT use retired	d)	ang	_			
2	ed wil	ပ္ပ	12				Owner		(First Mindella	Dry		ning	
nd	be file d oth even	Be	17. Father's Name (First, Middle, L					18. Mother's Nam	chy Bish		ie)		
<u>\$</u>	ould d Mer narke	ပ္	James Hennesse			10h Mailir	a Address (Street	and Number or Ru			State Zi	n Code)	
Maryland	12 st than 7 is n traun		19a. Informant's Name/Relationsh Rebecca Henness					d Circle				21114	
<u>မ</u> ်	1 and Heal tem 2		20a. Method of Disposition	ey/wiic	20b. PI	lace of Dispo	sition (Name of	i	Date	20c. Location -			
OL.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanshier must be notified at once.		1 <b>X</b> D <b>S</b> urial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate		natory`or other plac Ieaven Ce		/2009	Silver	Snri	no. MD	
Baltimore,	mit. F partm portar injur	1	21. Signature d'uneral Se vice L		111		2. Name and Addre			aylor F			
m	Der Der P		food	e. M	le	14	77 Duke o			_		, MD 21401	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death	. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
5	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Aspiration Pneuronia										
1	/Medical		resulting in death)	Due to (or	as a consequ	ience of):						•	
	Examiner	<u>.</u>	Sequentially list conditions,		ary br		ancer				_	5 months	
	ted nsit	nine	Sequentially list conditions, it is a sequentially list in resident cause. Enter Underlying Cause (Disease or injury that initiated events	Due to to	as a consequ	terice of							
	execun and al-train	Xar	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):							
8760,	cate be executed physician and the burial-transit	dical Examiner		d									
w			To person a		-			_					
Вох	death certifi e attending d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna th 2 🗆 Fetal		☐ Ectopic pregnan	су			ate of deli	very Day Year	
о Ш	e dea the at red fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unknov	nt at time of d vn	eath 5	Other (specify) _						
σ.	that the denet by the a		Part II. Other significant condition	ons contributing to dea	th but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did 1	tobacco use con	tribute to	the cause of death?	
Vital Records,	signe d be o	d by				J			1 🗆	Yes 2N∑X.No	3∏ Pro	bably 4 ☐ Unknown	
So	The law requires ate has been sign bage 2 should be	Completed							24a, Was	an 24b.	Were au	topsy findings available	
Re	The law cate has page 2:	E D								psy orm <u>ed?</u>	prior to c death?	ompletion of cause of	
ta			25. Was case referred to medical					26. Place of Dea	1 □Yes ath (Check only o	2ANo	1 ∐Yes	21110	
<u> </u>	di is	To Be	examiner? 1∐Yes 2 <b>K∏X</b> lo	Hospital:	patient 2	ER/Outpatie	nt 3 DOA	ner: 4 ☐ Nursing H	lome 5 ☐ Res	idence 6 □Ot	her (Spec	cify)	
J Of		Ę.	27. Manner of Death 1 XX Natural 5 ☐ Pending	28a. Date of (Month)	Injury , <i>Day, Year)</i>	28b. Time of Injury	Wo	ry at rk?	28d. Describe	how injury occur	rred		
<u>.</u>	at at	ă	2 ☐ Accident investig	gation				]Yes 2□No					
Division	or Attendatter deatt Director:	Certification:	3 Sulcide 6 Could r 4 Homicide determ	inod   20e, Place 0	f Injury - At ho g, etc. <i>(Specif</i>	ome, farm, st	reet, factory, office		City or To	Street and Num wn, State)	per or Hu	ral Route Number,	
	Hospital		29a. Certifier 1 <b>X XCertifyin</b>	ng Physician: To the b	est of my kno	wledge, dea	th occurred at the	time, date and place	e, and due to the	e cause(s) and n	nanner as	stated.	
	e Hos 1 24 ho e Fun letely	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	sis of examina	ition and/or i	nvestigation, in my	opinion, death occu	urred at the time	, date and place	, and due	to the cause(s)	
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date sign	ed (Month	n, Day, Year)	
			Mu in	<b>P</b>			D6	0390		Ju1y_	26,	2009	
0	1110		30. Name and address of person										
(1	AT 10		Adeeb Jaber 2 31. Date filed (Month, Day, Year)	2001 Medica	11 Park gistrar's Signa	way A	Annapolis	, Marylar	nd 2140	)1			
	Sta Regist		JUL 2	8 2009	new	B. A	back						

Amended items 23a,b,c Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per physician, 8/11/09; cs State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** P M August 1, 2:40 Geraldine Audrey Humberson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Grantsville Goodwill Mennonite Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 4, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Hours Min. Months Days 1□M 2**X**F Maryland 1930 79 <u>220-26-7675</u> Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show tes 1 □Yes 2K No Friendsville notified Director MD Garrett 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examing must be a death with USA 21531 539 Bear Creek Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify. ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Humberson Homes, Inc. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Corporate Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ot Be Pages 1 and 2 should be Thelma McLaughlin Thomas Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any Injury or other tra 539 Bear Creek Rd., Friendsville, MD Bruce F. Humberson/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 4, 2009 Friendsville, MD Humberson Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 Funcial Service 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD um e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart Immediate Cause (Fi rnmediate Cause (Final disease or condition resulting in death) 1 WEEK ASPIRATION PNEUMONIA **Physician** /Medical ue to (or as a consequence of) Examiner ADVANCED ALZHEIMER'S DISEASE YEARS SPIRATION Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed HDVANCED burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph for use as tf 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**N**0 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No after death.

Director: / 2 Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2. and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00034231 August 1, 2009 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) Robin Bissell, 124 Miller St., Grantsville, MD 21536 31. Date filed (Month, Day, Year) 32. Registrar's Signature State -3 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28b per MF C896 10/13/09 dk
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			for State Registrar	State of Ma	ii y lai lu		tificate of		and ivi	-	Reg. No		260	140
	Physicia	an	1. Decedent's Name (First, Middle, L	,						Date of De     Month		y Year	3. Time of	
	/Medic		Violet Faye	Hardesty			# 00 T	1 "		July		4, 2009	9:00	РМ
	Examin	er	4a. Facility Name (If not institution, g Mandrin Hospice				4b. City, Town, or	_	t Death			County of Dea		
	Funeral	7			(In yrs. las	t birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Bir				or Foreign
	Director		236-40-5120	1□ M 2√F	79	Yrs.	Months Days	Hours	Min.	8. Date of Bir Month, Da 7 / 13 / 1	930		thplace (State ountry) WV	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	cation				10d. Insi			ity Limits
	Mary I-f sh	ţor	TX Harris		Cvp	ress							1 □Yes	2□ No
	or 28g	Jirec	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What Co		
	23a c	Ta [	12502 Ravensway	Center Dri	ve #8	311	77429					U.S.A.		
	items	Funeral Director	11. Marital Status	12, Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig an, Mexican	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ame Black, Whit</li> </ol>		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, i'm Medical Eventinar must be notified at once.	ğ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐Yes 2 🔼 N If Yes, Give Year or Dates:	0	1	□Yes 2☐No	Specify:				Specify: V	Vhite	
Maryland 21215-0036	72 hou natura ilical E	Completed	15. Decedent's (Specify only highest g	Education		16a. Deced	lent's Usual Occup	ation	of workir	na	16b. K	(ind of Business	/Industry	
2	ine.	mpļ	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	OO NOT use retired	d)	or worter	.9				
, D	filed w Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Las	st)		Host	ess	18. Mothe	r's Name	(First, Middle		etail Surname)		
aŭ	ld be lental ked o	To Be	Jacob Earl Do					Flot			_	,		
ary	shoul and M s mar umat	F	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Numbe	er or Rura	l Route Numb	er, City	or Town, State,	Zip Code)	
Σ	and 2 ealth a n 27 is		Thomas Hardesty	(son)			Owensbro		t. We	est Riv	er,	MD 2077	78	
ore	t of Ho If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3	☐ Removal from State	1		sition (Name of natory or other plac			ate		ocation - City or		
Baltimore,	it. Pag rtmen rtant:		4 ☐ Donation 5 ☐ Other (Spec	cify)	At1		Cremato	- 1		/2009		en Burni		
Ba	Depa Impo any I		21. Signature of Funeral Service Lic	ensee			Name and Addre		mai	-		eral Hom D 21401	ne P.A.	
		2000	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each line	the death.	Do not ente	er the mode of dyir	ng, such as	cardiac o	r respiratory a	ırrest,		Approximat Interval Bet	ween
- Bar	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. 5h	6	Du	val	146	211	440	m	A	Onset and	
	/Medical Examiner		resulting in dealth)	Due to (or as a	consequer	nce of):		2						
		Jer	Sequentially list conditions,	b. Duk to (or as a	Linonesquer	roe of)								
	cuted nd ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	С										
, 20	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequer	nce of):								
68760,	icate t	<i>l</i> edical		d										
	certific nding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnance	y						23d. Date of de	livery	
Box	at the death cert I by the attending stached for use a	Physician/	in the past 12 months?	1 Live birth :			Ectopic pregnanc Other (specify)	y 			2	Month		Year
д О	at the	hys	9 □ Unknown	9 ☐ Unknown		-								UC
Š,	res th signed be de	þ	Part II. Other significant conditions	contributing to death bu	t not resulti	ng in the un	iderlying cause giv	en in Part I.				use contribute t	o the cause of o Probably 4□	
Š	requ been should	eted												
Records,	he law e has ge 2 s	Completed								24a. Was auto perfo	psv	prior to	utopsy findings completion of c	available cause of
		ပို ပို	25. Was case referred to medical	<u> </u>				26 Place	of Death	1 ☐ Yes (Check only o	2 No	o 1 □Ye:	s 2 No	
	ding Physician: h. After this certifica funeral director, p	0	examiner? 1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 EF	R/Outpatien	t 3 DOA Oth					6 Other (Spe	ecify) let	MICE
	ng Ph fter th	L:uc	27, Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day		8b. Time of Injury	28c. Injur Worl	y at k?	2	28d. Describe	how inju	iry occurred	/	1
<u> </u>	Attending r death. sctor: After by the funer	cati	2 Accident investigati 3 ☐ Suicide 6 ☐ Could not	he l		ınknov		Yes 2		Fel	114	hit	head	
Division	I or Atten after deatl Director: I in by the	Certification: To	4 ☐ Homicide determine	d 28e. Place of inju building, etc.	. (Specify)		_		2	City, or To	wn, Stat		lural Route Nun	nber,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best o	Tion		occurred at the ti	me, date an	nd place, a		cause(		as stated.	
	ne Ho n 24 h ne Fui	Medical	(Check only one) 2 Medical Ex	aminer: On the basis of and manner sta	examinatio ted.	n and/or inv	estigation, in my o	pinion, dea	th occurr	ed at the time,	, date an	nd place, and du	e to the cause(	s)
	Vwith com	Σ	29b. Signature and title of certifier		Del	04 th	29c. Licens		10	6	29d. Da	ate signed (Mon	th, Day, Year)	
	ELD		Mulha	- KA	DW	0		060	77	7	-	1/27	17	
	10		30. Name and address of person wh	o completed cause of de		3a) (Type, 8	(245	- (X	box	eril	A	210	315	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra			910		,,,,,			<i>U</i>		
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Please Type or Print in Black Indelible lak 1 Freyra All Copies Are Legible.
Amend Item 26 per DVK 6894 lak 1 Freyra All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jule 3:45 26° **Physician** 20109 Margaret Elizabeth Harnish /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Arbor at Baywoods Annapolis Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. 1 □ M 2 🖫 F Months Days Hours 213-20-3309 1/1/1921 Director 88 Sweden Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liquy or other traumatic event, the Medical Examiner mast he seemed once. 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Maryland Anne Arundel Annapolis 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA P.O. Box 6796 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ۵ Specify: White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Book Processing Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsa Kjellman ပ Lars Martenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 6796, Annapolis, MD 21401 David Harnish - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Hillcrest Mem Gardens 7/29/2009 | Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service License Myeli 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniscase of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 1 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate had director, page 1 □Yes 2 No ch 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 026373 Robert M. Greenfield 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 2 8

Annapolis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 8:45 AM JULY 28 2009 ANDREA LYNN JEDROWICZ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 👿 F Yrs. 217-96-5116 **MARYLAND** APRIL 16, 1964 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Count fshow 1 ☐ Yes 2 No Item 27 is marked other than "natural", or Items 23a or 28a-f st other traumatic event, the Modical Examines must be notified Director CHESTER QUEEN ANNE'S MARYLAND 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number UNITED STATES 21619 322 CASTLE MARINA ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 ▼ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PRIVATE DEFENSE Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTOR DATA ANALYST s 1 and 2 should be filed v if Health and Mental Hygie Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY ECKER BERNARD JEDROWICZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 322 CASTLE MARINA ROAD, CHESTER, MARYLAND 21619 BERNARD JEDROWICZ/FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition JULY 29 permit. Pages 'Department of H Important: If Ite any Injury or of 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND CHESAPEAKE CREMATION 2009 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that & used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner who no emiol Sequentially list conditions, if any, reading to mane liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to for as a consequence off-Examine requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Aspiration phlumona attending physician and Due to (or as a consequence of): Box 68760. Û varian Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an 1 ☐ Yes 2 **□** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ၉ 27. Manner of Death filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28 2000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 MEDICAL NNAPOLIS MO JABER ADEEB

State Registrar

JUL 30 2009

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0 7 200<sup>Year</sup> Day **Physician** Charles Baker Andal Jones 26 5:53pm<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bryans Road Prince George 6879 Arbor Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/14/40 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**⊠** M 2□ F 68 Ala. Director 422-54-7907 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10a State 10b. County Prince George 1 XYes 2 □ No Director Bryans Road Md 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 6879 Arbor Lane 20616 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11, Marital Status Black White, etc. 1 Yes 2 If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Retail 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alberta Vanltz Howard Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20616 6879 Arbor Lane Bryans Road, Md Patrick Jones Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 08/03/09 Riverdale, Md 4 □ Donation 5 □ Other (Specify) Riverdale 22. Name and Address of FacilitySnead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee 1409 Fairlakes Pl Ste B Bowie, Md 20721 Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine be execute and burial-trar that initiated events resulting in death) Last Due to (or as a consequence Box 68760, physician Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 5 Other (specify) P.O. the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 1 ☐ Yes 3 Probably 4 Unknown director, page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To to this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. To the I within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD BRANCH AU 31. Date filed (Month, Day, Year)
JUL 31 2009 State Registrar

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Dhusia		1. Decedent's Name (First, Middle, Last)			<del></del>	2. Date of De		Voor	3. Time of Death
Physic /Medi		Rembert F. Jones Jr.				July	' -	Year 2009	4:03 A M
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Tow	n, or Location of I	Death	4c. Count	y of Death	
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Funeral		1 <b>K</b> M 2□ E	(In yrs. last birthda	Months Da		Min. (Month, Da	th ay, Year)	Cou	place (State or Foreign ntry)
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iii th	Dire	10e. Street and Number		10f. Zip Coo			10g. Citizen of	What Cou	ntry?
ath w	ra	2907 Bidle Road			21769		Unite	d Sta	ites
er de	Completed by Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 1	<ol><li>Was Decedent If Yes, specify 0</li></ol>	of Hispanic Origir Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	)- 14. Ra Bla	ice - Ameri ack, White,	
OUSO hours aft ural", or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ※ N If Yes, Give Year or Dates:	0	1 □ Yes 2 <b>火</b> □	No Specify:		Speci	ify: W	Mite
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VIZI Ould to Men arke	ျ	Rembert Jone, Sr.			_ Do	orothy Gri	ffin		
2 sh h and rism		19a. Informant's Name/Relationship (Type. Print)	<b>I</b>			or Rural Route Numb	-		o Code)
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or of or		20a. Method of Disposition  1 🗆 Burial 2 🖎 Cremation 3 🗆 Removal from State	cemetery, c	sposition (Name or rematory or other	place)	Date	20c. Location	•	
perfull Ofe, INIGITY IGIO 2 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experient must be notified at once.		4 Donation 5 Other (Specify)	Stauffe	er Cremat		7/31/2009			
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KB		30. Name and address of person who completed cause of de	oth (Itom 00-) (T	o Brint'	D006725	00	July	30,	2003
10					Drive.	Rockville	, MD	20850	
Sta	te	04 D-1 (1 1/14 // D W-1)							
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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** Francis William July 28. 5:45P <sup>M</sup> Kilinski, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles La Plata
If Under 1 Year If Under 24 Hrs. 214 Morgans Ridge Court 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) March 7,1943 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Months 1 X M 2 □ F 213-44-6542 Maryland 66 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinating by rudified at once. 1 Yes 2 No Director MD Charles La Plata 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 214 Morgans Ridge Court 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No White Specify: ģ 3 ☐ Widowed 4 反 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ Sheriff Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Kilinski Dorothy Hardesty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Landicho/Daughter 214 Morgans Ridge Court, La Plata, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Newport Cem. 8/3/2009 Charlotte Hall,MD 22. Name and Address of Facility M00945 AREHART-ECHOLS FUNERAL HOME, P.A. a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascolo **Physician** 00 523 ENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

2 Hours after death.

Pureral Director: After this certificate has been signed by the attending physician and elely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of July 31, 2009 30.: Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 0 ld line Contro Walter 2N. tanas 100 31. Date filed (Month, Day, Registrar's Signature State 312009 MIL Backs Registrar

1 - For State Registrar

	/Medi	cal	George Eugene	Kline				August		2009	10:02	2 <u>A</u> ™
	Examir	ner	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of De	eath	40	c. County of De		
		- 1	Washington Count			Hagers				Washir		
	Funeral Director		217-28-5493	Sex IXIM 2□F	79 Yrs	Months Days		lin. 8. Date of B (Month, D April	ay, Year	1930 9. E	Birthplace (State Country) Marylar	
	and w		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town o	r Location					10d. Inside	City Limits
	ne Maryla Ba-f sho btifled at	Funeral Director	Maryland Washing		Sharpsb						1 ☐ Ye	es 2 No
	or 2	Dir	10e. Street and Number			10f. Zip Code				itizen of What	Country?	
	ath w	ā	2304 Chestnut Gro			21782				S.A.		
	er de	nue	11. Marital Status	12. Was Decedent Even Armed Forces? 1 2 Yes 2 No If Yes, Give	er in U.S.	<ol> <li>Was Decedent of If Yes, specify Cu</li> </ol>	Hispanic Origin? ban, Mexican, Pi	' (Specify Yes or N uerto Rican, etc.)	lo-	14. Hace - Ar Black, W	merican Indian, hite, etc.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	d by F	1 ☐ Never Married 22 Married 3 ☐ Widowed 4 ☐ Divorced	1 Mayes 2 ☐ No If Yes, Give Year or Dates:	1968	1 □ Yes 2 🛣 No				Specify:	White	
5	72 h	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. D	ecedent's Usual Occi Give kind of work don fe. DO NOT use retir	upation e during most of	working	16b. l	Kind of Busine	ss/Industry	
	filed within Hygiene. other than ent, the Me	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		tionary E	ngineer				rection	ıs Dept
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last				18. Mother's I	Name (First, Middl	e, Maide	n Surname)		
Maryland	2 should be filed and Mental Hygic is marked other aumatic event, the	ဥ	Merle R. Klir				Mary		De1a			
a	2 sho and is m		19a. Informant's Name/Relationship (	Type. Print)	19b. M	failing Address (Stree	et and Number or	Rural Route Num	ber, City	or Town, State	e, Zip Code)	
	1 and Health em 27 Ither tr		Betty L. Kline /	Spouse		04 Chestn				sburg,		782
ore	of Herriter		20a. Method of Disposition 1 Durial 2 □ Cremation 3 □	Removal from State	<ol> <li>Place of D cemetery,</li> </ol>	isposition (Name of crematory or other pl	ace)	Date	20c. L	_ocation - City	or Town, State	
Ē	Pages ment of I ant: If its ury or o		4 Donation 5 Other (Special		Samples	Manor Ce		08/2009	Sha	rpsbur	g, Mary	land
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Funeral Service Lice	Las		Bast-Stau 7606 Old 1	ress of Facility Fier Fun Vational	eral Home	e, P	.A.		
*			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th	e death. Do not					0010	Approxim Interval B	
200	Physician	8 1	Immediate Cause (Final	/		- 1					Onset and	d Death
	/Medical		disease or condition resulting in death)	Due to (or as a		f Failure					3 wee	<b>X</b> 2
	Examiner		Preumania								3 440	u.
	2,*	ē	Sequentially list conditions,	b. Duly to (or as a c	to onnaupelenor	Her					- Jove	<u> </u>
	uted d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events	R	anal 2	allure					3 wee	k.
Ć,	e exectian and	Examiner	C. Kenal failure that initiated events resulting in death) Last  Due to (or as a consequence of):  Anti-C Anegrysm									7,3
68760,	eath certificate be executed attending physician and for use as the burial-transit	dical	d. Aostic Anegrysm								year	3
Box (	certif	/Me	IF FEMALE:	23c. If yes, outcome pf					23d. Date of	delivery		
.O. Bo	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	d. Antic Analysm  d. Aothic Analysm  23c. If yes, outcome pf pregnancy								Month	Day	Year
<u>α</u>	- 0 0	<u>a</u>	Part II. Other significant conditions	contributing to death but	not resulting in th	ne underlying cause o	iven in Part I.	23e. Did	tobacco	use contribute	e to the cause o	f death?
ds,	signe	by									Probably 4	
Records,	The law requires that ate has been signed bage 2 should be det	Completed		rtension nany artery mative t	M -					7		
3ec	in so	ğ	Corol	rang arrery	nsign	K			opsy	prior	autopsy finding to completion of	s available cause of
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Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					Death (Check only	one)			
or	di Si	유	1 Yes 2 No			Atlent 3 DOA		g Home 5□Res			Specify)	
ion	ding After fune	ation:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		(ear) 28b. Tim	iry W	ury at ork? ∐Yes 2 ☐ No	28d. Describe	e how inji	ury occurred		
Division	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		- At home, farm (Specify)	, street, factory, office	9	28f. Location City or To	(Street a own, Sta	and Number or te)	Rural Route Nu	ımber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	70	29a. Certifier (Check only one) Certifying Pt 2  Medical Example 1  Medical Example 1  Medical Example 1  Medical Example 2  M	nysician: To the best of miner: On the basis of each manner state	my knowledge, oxamination and/o	death occurred at the or investigation, in my	time, date and p	lace, and due to the	e cause( e, date a	s) and manner nd place, and	r as stated. due to the cause	e(s)
	Fo th Withir	Me	29b. Signature and the of certifier	1		29c. Licer	nse number		29d. D	ate signed (Me	onth, Day, Year)	)
			) Trans			D4	4496		Augu	ust 4,	2009	
			30. Name and address of person who	completed cause of dea	th (Item 23a) (Tv	rpe, Print)	-					
5	H-15H		Lafar Ma	lik MD	20311 (a	phans Rd	Boonsb	no MI	14,	113		
	Sta Registi	ne rar	AUG 0 4	2009		6.41						
Check only   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.   29c. License number   29d.   29b. Signature and the of certifier   29c. License number   29d.   29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)   29c. License number   29d.   29d.												

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please Type or Print in B						
		State of Maryland  1 - State Registrar		artment of He tificate of De			giene 009	26047
Physici /Medic	an	1. Decedent's Name (First, Middle, Last) Donald	Ki	pfer		2. Date of Dea Month	Day Year 2009	3. Time of Death 9:05a <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital		4b. City, Town, or Lo			4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex $1000$ 6. Sex $100$ 7. Age (In yrs. lass $100$ 60	st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day APRIL 8	(, Year) Cou	hplace (State or Foreign untry) XAS
ryland show at			Town or Loc	cation				10d. Inside City Limits  1X Yes 2 □ No
th the Ma or 28a-f	2	MARYLAND PRINCE GEORGE'S BOW 10e. Street and Number	IE	10f. Zip-Code			10g. Citizen of What Co	
sath wis 23a	la	12312 MANSHIP LANE  11 Marital Status 12. Was Decedent Ever in U.S.	113 \	20715		cify Yes or No-	U.S.A.	rican Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 🗶 No	Mexican, Puerto F	Rican, etc.)	Black, White Specify: WI	e, etc.
n 72 hou I <b>"natura</b> edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng	16b. Kind of Business, REAL ESTA	
d withi giene. er than the M	Comp	Elementary/Secondary (0-12) College (1-4 or 5+)	M/	ANAGEMENT			PROPERTIE	S
l be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last) DONALD CHARLES KIPFER, SR.			8. Mother's Name EDNA MAE	, ,	, Maiden Surname) 7	
d 2 should th and Me 7 is mark traumatic	욘	19a. Informant's Name/Relationship (Type. Print) JANE F. KIPFER/WIFE			nd Number or Rura	al Route Numb	er, City or Town, State,	Zip Code)
ss 1 and of Healt item 2 r other	lycel 	20a. Method of Disposition 20b. Pla  1 X Burial 2 Cremation 3 Removal from State	ace of Dispo	osition (Name of matory or other place)	D	ate	20c. Location - City or	
Page Iment tant: If		4 Donation 5 Other (Specify)	LINCO	LN CEMETER	RY 7/27/		BRENTWOOD,	
permit Depar Impor any In once.		21. Signature of Funeral Service Licensee					EVANS FUNE	
		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying.	, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician / / / / / / / / / / / / / / / / / / /		Immediate Cause (Final disease or condition resulting in death)  a. Dug to (or as a consequence)	renic	< S/	OCK			Onset and beauti
Examiner	L	Munearelis	al	Mag	ction	1.		
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):	0				
e executed an and urial-transit	al Exa	that initiated events ' c Due to (or as a consequence consequence)	ence of):				7	
tificate be ex g physician a	edic	d			•			
eath certifi attending d for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 3 □ Fetal 2 □ Fetal 3 □ Fetal 2 □ Fetal 3 □ Fetal	death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
es that the designed by the at	hysic	1   Yes 2   No 9   Unknown	alli 5	Other (specify)				
w requires that been signed t	by	Part II. Other significant conditions contributing to death but not resu	ulting in the u	underlying cause give	en in Part I.	23e. Did t	tobacco use contribute t	robably 44 Unknown
e la has	Completed			_		24a. Was autor perfo Yes	rmed?   death?	utopsy findings available completion of cause of s 2 \( \subsection \) No
sician: Th certificate irector, pa	Be C	25. Was case referred to medical examiner?			26. Place of Death	(Check only o	ne)	
Physic this ce	2	27. Manner of Death 28a. Date of Injury	28b. Time o	of 28c. Injury Work?	4   Nursing no		dence 6 Other (Spe how injury occurred	ecify)
Attending Physician: r death. sctor: After this certifics by the funeral director,	ertification	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	Injury	M 1 □ Ye	es 2 No		<u>.</u>	1
al or Att	Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)		reet, factory, office		28f. Location ( City or Tov	(Street and Number or F vn, State)	Rurai Houte Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical (	29a. Certifier (check only one) 2 Medical Examiner: On the best of my know and manner stated.						
To the comp	Me	29b. Signature and title of Certifier	•	29c. License	number	^ ~	29d. Date signed (Mon	th, Day, Year)
		30. Name and address of person who completed cause of death (Item	23a) (Tune	Print)	5 - 00		July 23	2007
#10.		AMIR FLHASSAN	4	,9	600 1	North Wo	olfe St, Baltim	ore, MD, 21287
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 2 9 2009  32. Registrar's Signatu	<b>A</b> . <b>4</b>	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . <sup>Day</sup> 2009 21:40 P M **Physician** July 27, Mardelle Lagana Echolene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern MD Hospital Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 77 Yrs. Bedford. 38 9076 Nov 17. **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be redilled at 1 □Yes 2XXNo Clinton Director P.G. MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20735 8009 Colonial Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 TWo If Yes, Give XX Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7th College (1-4or 5+) Own Home Homemaker 12 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any injury or other traumatic ev Ida Pearl Lee Ira Bryant Johnson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6354 Northbrook Drive, Dunkirk, MD 20754 Angela Jones (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 4, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Cheltenham, Maryland Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death to not enter the mode of lying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **∂** 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

ne Funeral Director; Affoletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2. the bay, Year) 29d. Date signed (Month, 29c. License number 29b. Sig

State

Registrar

park

Rodriguez Felipe, M.D. 11701 Livingston Road, Fort Washignton, MD 20744

30. Name and address of person who completed cause of death (tien-23a) (Type, Print)

JUL 3 1 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per yn C895 9/16/09 JH
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 July **Physician** Mark Louis Lipsky 26, 4:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1949 (Month, Day, Year) 5/28/1<del>948</del> 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthpiac Country) MA 1 ☐ M 2 ☐ F Months Days Hours Min 014-40-4776 60 Director Usual Residence of Deceden nd 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural" or items 23a or 28a-f show traumatic event, I'm Mactical Examinary. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1□Yes 2□No MD Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 142 Georgetown Road #3 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Furniture Sales Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jules M. Lipsky Tillie Engelsman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. 142 Georgetown Rd. Annapolis, MD 21403 Deborah Snyder Lipsky (wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 15 ☐ Other (Specify) 7/28/2009 | Annapolis, MD Kneseth Israel Cem. 22. Name and Address of Facility Hardesty Funeral Home P.A. 21. Signature of Funeral S. vige Licensee 7 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Due to ( r as a consequence of): disease or condition resulting in death) Dulmonary /Medical Examiner Sequentially list conditions, any, cause to minimize cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No After this certific funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and http of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Pwky, Annapolis MD (Ex0) JUL 28 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 12:35 5, Walter Clarence Lee, Sr. August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 7520 Maryland Highway Garrett Swanton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Hours 1 X M 2 □ F 217-28-9354 May 4, 1933 Maryland 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modbert Evaning must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 ☑ No Director MD Garrett Swanton 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 7520 Maryland Highway 21561 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2X Married 2□No 1953 -1 ☐ Yes 2**K** No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 1955 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad & paper plant Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carder Lucinda Jacob Rodrick Lee Mae ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7520 Maryland Highway, Swanton, MD 21561 Elizabeth L. Lee, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Cumberland Crematory 8/7/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A.
21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEcline & wt loss **Physician** GENERAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner yeer tersion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Rhownortc physician and s the burial-trans Aorki Due to (or as a consequence of): Physician/Medical SE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 T Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò COPD Yes 2 No 3 Probably 4 Unknown Certification: To Be Completed |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

sertificate be executed

		/									
				24a. Was an autopsy performed? 1 □ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1∐ Yes 2√No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DC	OA Other: 4 🗆 Nursing Ho	ome 5 🛣 Residence 6	Other (Specify)						
27. Manner of Death  Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred						
3 Suicide 6 Could not l		ome, farm, street, factory fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier Check only one)	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place , in my opinion, death occur	, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)						

d title of gertifier 29b. Signature a

29c. License number 20035 29d. Date signed (Month, Day, Year) 8/172009

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

OPEKLAND MD MEMORIAL DRIVE Richtes 1533

State Registrar

Medical

ONACD

31. Date filed (Month, Day, Year)

			For State Registra	ND#23a(a);	State of termo7/31/09			artment of F rtificate of			, ,	giene leg. No.2	009	26(	051
			Decedent's Nam								2. Date of Dea Month		Year	3. Time of	Death
11.4	Physici /Medio		Yelena	Libers							July 25	2009	1001	5:45	М
	Examir	ner	4a. Facility Name (	If not institution,	give street and numb	er)		4b. City, Town, o		of Death			nty of Death		
-			Suburban 5. Social Security N			Age (In yrs. la:	et hirthday)	Bethe If Under 1 Year		r 24 Hrs.	8. Date of Birth		t gome	ry place (State o	or Foreign
	Funeral Director		219-27-3		1□ M 2X F	85		Months Days	Hours		(Month, Day 7/13/19	(Year)	Cou	intry) craine	or or origin
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	arylar show	5	10a. State	10b. County		10c. City,	Town or Lo	ecation						10d. Inside C	ıty Limits 2 ☐ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations to it cultified at	Director	MD 10e. Street and Nu	Montgo	mery	Ве	these	10f. Zip Code			1	I0g. Citizen o	of What Cou		
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9	or ite		1 X Never Marr	ried 2□ Marrie	d 1 ☐ Yes 27			iryes, specify Cub 1 ∐Yes 2 <b>X</b> INo			rican, etc.)	Spec	lack, White,	etc.	
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<u>ylaı</u>	Ments Ments arked atic e	욘	Unkno	wn and	Unknown				Ro	osa Li	ibers	_			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, Ite Medical once.		19a. Informant's N	ame/Relationshi	(Type. Print)			ng Address (Street						•	
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Baltimore,	ages int of t: If its		1 🛛 Burial 2	☐ Cremation 3	Removal from Sta	ite		sition (Name of natory or other place	i				,		
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	/ /Medical		resulting in death)	-		as a conseque			LOGI	010					
4	Examiner	<u>.</u>	Sequentially list co	onditions,				rt Failur	Ce .				_		
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<u>Э</u> а.	that the led by th detache				s contributing to deat	h but not result	ting in the u	nderlying cause giv	ven in Part	: I.	23e. Did to	bacco use co	ontribute to	the cause of	death?
7/25/ Records,	requires een sign oould be	Completed by		Periphe	eral Vascu	lar Dis	sease				1 □ Y	es 2 No	3 □ Pro	obably 4X	Unknown
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lena of Vital	Physician: this certific al director,		examiner? 1∐Yes 2 <b>X</b>	]No	Hospital: 1X Inp	atient 2 E	R/Outpatie	nt 3 □ DOA Oth	her: 4 🗆 N	Nursing Hor	ne 5 🗆 Resid	ence 6 🗆 🤆	Other (Spec	cify)	
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Sio	Attending r death. ector: Afte by the fune	icati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	4.5-	Jaium, At ham			Yes 2		206 Lagation (C	Name and Advanced Advanced	makov av Du	m / Davida Alvin	
rs, Ye	or Ar after of Direction by	Certification: To	4 ☐ Homicide	determin	ed 28e. Place of building	, etc. (Specify)	ne, iarm, sti	eet, factory, office		2	28f. Location (S City or Tow	n, State)	mper or Hu	rai Houte Nur	nper,
Bers	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:		29a. Certifier	1 Certifying	Physician: To the be	est of my know	ledge, deat	h occurred at the t	ime, date	and place,	and due to the	cause(s) and	manner as	stated.	
0-	the Ho hin 24 h the Fu npletely	Medical	(Check only one)	2 Medical E	kaminer: On the basi and manner		on and/or ir	vestigation, in my	opinion, de	eath occurr	ed at the time, o	date and plac	e, and due	to the cause(	s)
-	To the complete of the complet	Ž	29b. Signature and	title of certifier	Cons	HAN SIV	.4.	29c. Licens				29d. Date sig	1	, Day, Year)	
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	Registr		11	L 31 2	009 Person	N B.	par	Kil							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 21st 2009 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE WASHINGTON MEDICAL 9. Birthplace (State or Foreign Country) ANNE EUTER 8. Date of Birth (Month, Day, Year 04/23/1947 Social Security Number If Under 1 Year . Age (In yrs. last birthday) Funeral Min 1 □ M 2 □ F Months Days Hours Syria Director 154-78-7776 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at 1 ☐ Yes 2 🛣 No Maryland Anne Arundel Millersville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Millwright Court, #41 21108 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ Specify: 3 Widowed 4 □ Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental Iskouhi UNKNOWN Kyriacos Kyriakides 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn M. Tsourounis/Daughter : If item 27 or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Kalas Crematory 07/25/2009 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Funer 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Imme late Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is double and ner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Examil and burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate perform 1 ☐ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2☐ Accident investigation within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my calculated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

5 W

Registrar

30. Name and address

DHMH 17 Rev 1/2001

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

26053

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at any injury or other traumatic event, the Medical Evantiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	Registrar			Cerun	icale of	Deal	.11	F	leg. No. 🛴 🛝		20000			
	Decedent's Name (First, Middle, Last				Date of Dea     Month	th Day	Year	3. Time of Death						
_		an, Sr.					July 20			1:00 P. <sup>™</sup>				
	Facility Name (If not institution, given 9428 Washington B				. City, Town, Seabro	_	on of Death		4c. Coun		eorge's			
	Social Security Number 6. Se		(In yrs. last birt		Under 1 Yea		der 24 Hrs.	8. Date of Birtl	1	9. Birt	thplace (State or Foreign			
		XM 2□ F 83	-		onths Day			(Month, Day	(, Year)		ountry) liana			
	ual Residence of Decedent							3000	, 17 - 5					
	a. State 10b. County	. 1	10c. City, Town		on						10d. Inside City Limits			
Ma	aryland Prince G	eorge's	Seabro	ok							1 □Yes 2X No			
	e. Street and Number 9428 Washington B	1vd		1	Of. Zip Code 20706				10g. Citizen of What Country? U. S. A.					
3		12. Was Decedent E	ivas in II C	12 1/100			Origin? (Sr	pooify Voc or No			erican Indian,			
11.	. Marital Status 1 □ Never Married 2 ☒ Married	Armed Forces? 1 XYes 2 □ N		If Ye	s, specify Cu	iban, Mexi	ican, Puerto	pecify Yes or No- Rican, etc.)		ack, White	e, etc.			
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 '	Yes 2∭XN	o Spec	ify:		Spec	ify: Wł	nite			
ourpleted by	15. Decedent's Edu (Specify only highest grad	ucation	16a.	Decedent'	s Usual Occ	upation	nost of work	dina	16b. Kind of	Business	/Industry			
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	12		Me	chan	ic For						Company			
5	17. Father's Name (First, Middle, Last)  Robert McGowan  18. Mother's Name (First, Middle, Maiden S Rose Avery									ime)				
-	Pa. Informant's Name/Relationship (7	voe. Print)	19b.	Mailing A	ddress (Stre	et and Nu	mber or Ru	ral Route Numbe	r. City or Tow	n. State	Zip Code)			
	Lois E. McGowan/W							Seabroo						
20	a. Method of Disposition	Romaval from State	20b. Place of cemeter	Disposition y, cremato	n (Name of ry or other p	lace)	1	Date	20c. Location	- City or	Town, State			
	1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Atlant	ic C	remato	ry	7/21/				ie, Maryland			
21	I. Signature of Funeral Service Licens	see • //								Funeral Home,				
	Har f. T.	neces		1600	00 Ann	apol:	is Roa	ad, Bowi	e, Mar	yland				
23	<ol> <li>Part 1. Enter the disease, or comp shock, or heart failure. List only or</li> </ol>	lications that caused one cause on each lin	the death. Do n e.	ot enter th	ne mode of d	lying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death			
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that re	at initiated events sulting in death) Last	C. Due to (or as a	consequence of	of):										
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23	bb. was decedent pregnant	23c. If yes, outcome of	of pregnancy	3∏Ec	tonic pregna	ncv				ate of de				
200	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at			her (specify)					<i>l</i> lonth	Day Year			
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Pa	rt II. Other significant conditions co Diabetes Mellitus	-	τ not resulting in	the under	iying cause	given in Pa	art I.				o the cause of death?			
- ا يُ								1 🗆 Y			robably 4 Unknown			
	Dysphagia							24a. Was autop	an 24t	. Were a prior to	utopsy findings available completion of cause of			
3								perfo	rmed?	death?	s 2 No			
25	b. Was case referred to medical examiner?	Hospital:				)thor:		th (Check only o						
1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 KD Residence 6 Othe										ecify)				
5   "	1 Natural 5 Pending 2 Accident investigation	(Month, Day	(Year)	njury		juryat ′ork? □Yes 2	2 □No	-od. Describe I	www.mijury.occi	anou				
2	3 Suicide 6 Could not be		ry - At home, far					28f. Location (5	Street and Nur	nber or R	Pural Route Number,			
5	4 Homicide	building, etc	. (Specify)					City or Tov	n, State)					
27	(Check only 2 Medical Exam	ysician: To the best on hiner: On the basis of	examination an											
	one)  3b. Signature and title of certifier	and manner sta	ied.		29c. Lice	nse numb	er		29d. Date sigr	ned (Mon	th, Day, Year)			
	Prife	in S	0			D289	98		July °					
30	Name and address of person who coefficients. Saini,	completed cause of de	eath (Item 23a) ( Cherry I	Type, Prin	Suite	211	, Lau	rel, MD	20708					
31. Date filed (Month, Day, Year)  32 Registrar's Signature  4. Sault										· -				
	AAF N I CO	UU KERKME	J D. 1											

Stat Registra 1. Decedent's Name (First, Middle, Last)

July **Physician** 2009 6:50 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster 1508 Bachman Valley Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/18/1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 213-20-6149 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evantiner must be radified at any injury or other traumatic event, I'm Medical Evantiner must be radified at appres. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Centreville Queen Anne's 1 □Yes 2 ▼No Maryland Director 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 21617 United States 204 Heritage Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: 2 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Food Service Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Golda Robinson Robert Blake ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 204 Heritage Way, Centreville, Maryland 21617 Brenda Joyce Calder/Daughter 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park July 28, 2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A 21. Signature of Fundal Service Lice 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Weeker Preumanis /Medical Due to for as a consequence of) **Examiner** Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Etrial Fulletin 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Valvaler heart 13 rese 24a. Was an Smell bould Obstractio-1 ☐Yes 2 ☐ No 1 □Yes 2 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No Il Director: / investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 041339 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 SALLITT DRIVE SPENSYLLE HARMS 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** TRACY Μ. MCMULLEN 23, JULY2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2XXF Yrs 44 Director 220-82-3040 JUNE 29. 1965 WASHINGTON, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or them. The marked other than "natural" or them. 10a. State 10c. City, Town or Location Funeral Director DAVIDSONVILLE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2603 CORLETO COURT 21035 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2 No 1 X Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CHARLES COUNTY College (1-4or 5+) Elementary/Secondary (0-12) 5+ GOVERNMENT TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F. MCCARRON JOHN MCMULLEN PATRICIA 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2603 CORLETO COURT, DAVIDSONVILLE, MARYLAND 21035 SEAN MCMULLEN/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State AKEMONT MEM GARDENS 7/27/2009 DAVIDSONVILLE, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, 21. Signature of Funeral Service Licensee 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records. P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 2 No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗷 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

3. Time of Death

4:10 P.

Birthplace (State or Foreign Country)

Black, White, etc.

Month

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month) Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Day

3 Probably 4 Unknown

Vear

10d. Inside City Limits 1 ☐ Yes 2X No

Approximate Interval Between Onset and Death

State Registrar

Certification: To

Medical

After

within 24 hours after death To the Funeral Director:

31. Date filed (Month, Day, Year)

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 □ Could not be

1 npatient

28a. Date of Injury (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifie

(1

3 Suicide

29a. Certifier

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28°, July 2009 11:45PM William I. Moorman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner P.G. Largo ManorCare Largo If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
2-25-28 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1 M 2 □ F 81 Yrs. Phila. Pa. Director 146-22-5589 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Accipal Exemiting in set to notified at 1 X Yes 2 □ No Director P.G. Fort Washington MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 U.S.A. 2416 Grange Hall Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Forcesr

| Tax'es 2 | No | 10/24/50 1 | Yes 22 | No | Spirit |
| Yes, Give 10/16/52 |
| 16a. Decedent's Usual Occupation |
| 16a. Decedent | 16a. Decedent's Usual Occupation |
| 16a. Decedent | 16a 1 Never Married Married Saltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fed. Gov't Inventory Mgr Specialist 12 should be filed w h and Mental Hygiei 7 Is marked other th 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Carberry William B. Moorman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is n any Injury or other traun 2416 Grange Hall Ct. Ft. Wash. Md. 20744 Ida B. Moorman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Md. 8/6/09 Cedar Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura f Funeral Service License Name and Address of Facility Hackett's Funeral Chapel, 814- Upshur Street, N.W. to w Nac 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause disease or condition resulting in death) mediate Cause (Final **Physician** Levere congestive /Medical Due to (or as a consequence of): **Examiner** nonic obstruc Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit Due to (or as a consequence of): and Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 2 No signed by the a □Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Hospital or Attending Physician: The 24 hours after death, Funeral Director: After this certificate h performed 1 ☐ Yes 2 ☐ No 2**X** No 1 □Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide

To the within 2.

29d. Date signed (Month, Day, Year) July 29, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meklit Workneh, M.D. 7705 Belle Point Dr. Greenbelt, Md. 20770

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D62116

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

32 Registrar's Signature 31. Date filed (Month, Day, Year) JUL 31 2009

and manner stated

	4	State of Maryland / Department of Health and In State  State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health and In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department of Health And In State of Maryland / Department /	Mental H	ygiei Reg. l	00	119	26057
Physician	_	1. Decedent's Name (First, Middle, Last)  MARGARET HENRY PENICK NUTTLE	2. Date of D		<sup>2</sup> 2009	/ear	3. Time of Death <b>0700 A</b> <sub>M</sub>
/Medica Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6020 SHIPYARD LANE  EASTON	1		4c. County of	Death	r
Funeral Director		5. Social Security Number 220–46–1129  6. Sex 1 M 7. Age (In yrs. last birthday) 1 Months Days Hours Min.	8. Date of B (Month, I	irth Day, Yea	1913	9. Birthpl Count	ace (State or Foreign ry) <b>NJ</b>
Maryland -f show ied at		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location           MD         TALBOT         EASTON				10	id. Inside City Limits 1 □Yes ★★No
h with the 23a or 28a	runeral Director	10e. Street and Number 10f. Zip Code 6020 SHIPYARD LANE 21601		10g.	Citizen of Wh	nat Count	ry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be retified at once.	<u></u>	11. Marital Status  1  Never Married 2  Married 3  Married 4  Divorced 1  Married 5  Married 5  Married 6  Married 7  Married 8  Married 8  Married 8  Married 9  Married 9  Married 1  Married 9  Married 1  Mar	pecify Yes or Noo Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE				re.
21215- 1 within 72 giene. r than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  HOMEMAKER	king	160.	. Kind of Busi		ustry
Baltimore, Maryland 21215-0036  Bernit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene.  Important: If flem 27 is marked other than "natural", or any Injury or other traumatic event, I'm Medical Examinance.	o pe c	17. Father's Name (First, Middle, Last)  SYDNOR BARKSDALE PENICK  18. Mother's Nam MARGAE	ne (First, Middi		·	)	
Mary and 2 sho alth and 27 is ma or trauma		19a. Informant's Name/Relationship (Type. Print)  EMILY D.N. FUCHS DAUGHTER  19b. Mailing Address (Street and Number or Ru  603 BRIGHTWOOD CLUB I			-		*
more, Pages 1 a ent of He ent of He ry or othe		20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  OLD WYE CEMETERY  8-4-	Date -2009		Location - C		•
Baltii permit. F Departm Importar any Injur		21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN	N & NEW	NAM	FUNER	AL H	
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	or respiratory		ID 210	01	Approximate Interval Between Onset and Death
/ /Medical Examiner		Due to (or as a consequenct of):  Sequentially list conditions  b.					
68760, tificate be executed g physician and as the burial-transit	a Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to for as a consequence of:  C.  Due to (or as a consequence of):				1	
	riiysiciali/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1			23d. Date Mont		ry Day Year
P.O. hat the d ad by the detached		1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9	23e. Dio	f tobacc	co use contrib	oute to th	e cause of death?
Records, F ne law requires that s has been signed t ge 2 should be dete	2						ably 4 ☐ Unknown
	pajaidillos	25. Was case referred to medical 26. Place of Dea	per 1 □ Yes	opsy formed 2 2	2 pri	or to con ath?	sy findings available npletion of cause of
Physicla this cert al directo		examiner?  1   Yes   2   Mo   Other: 4   Nursing H	ome 5 Re	sidence		-	)
Division of to Attending Phy after death. Director: After this in by the funeral d	Callon	27. Mann of Death  1	28d. Describe	e how in	njury occurred	1	
Division of Vita To the Hospital or Attending Physician: Within 24 hours after death. Dithe Funeral Director: After this certific completely filled in by the funeral director.		4 Homicide determined building, etc. (Specify)	City or To	own, St	tate)		Route Number,
the Hospital in 24 hours in the Funeral in pletely filled	בחוכשו	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and of the time, date and place 2 Medical Examiner: On the basis of examination and of the basis of examination and of the basis of examination and other and t	e, and due to the irred at the time	e, date	e(s) and man and place, ar	ner as st nd due to	ated. the cause(s)
To the Complex	Ā	29b. Signature and title of certifier  29c. License number  39 S8	7	29d.	Date signed	(Month, E	Day, Year)
ĝo		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Dri	R	Ea	sto	n Hb/
State Registrar		31. Date filed (Month, Day, Year)  32. Registrar's Signature					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato or ma	ryiana / L	Cer	tificate of D	Death	Re	g. No.			
	Dhuaisi		1. Decedent's Name (First, Middle, Las						2. Date of Death Month	Day	Year	3. Time of Death	
	Physicia /Medic		Clark	Frederic	No	rtor			July 22,	2009		10:30 P. <sup>M</sup>	
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death			nty of Death	George's	
yet <sup>6</sup>			3614 Melfa Lane  5. Social Security Number 6. S	ev 7 Age	(In yrs, last bir	rthday)	Bowie If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign	
	Funeral Director		374-20-0845	X M 2□F 9	, ,	Yrs.	Months Days	Hours Min.	April 18	, 191	2 Micl	nigan	
	and sw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	Location 10d. Inside City Limits						
	Maryl -f sho	tor	Maryland Prince (	Penroe's	Bowie							1 X Yes 2 ☐ No	
	n the	Director	10e. Street and Number	200180 0			10f. Zip Code		10	g. Citizen	of What Cou	ıntry?	
	th wit	ral	3614 Melfa Lane				20715			U. S			
	tems tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ∐Yes 2 X No	ver in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amei Black, White		
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Medical Exactified at aggre.	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 📉 No If Yes, Give Year or Dates:	0	1	□Yes 2XNo	Specify:		Spe	ecify: W	hite	
ה ה	72 hc	Completed	15. Decedent's Ed (Specify only highest gra		16a	(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	ation Luring most of work	ing	6b. Kind o	f Business/I	ndustry	
7	within sne.	mp	Elementary/Secondary (0-12)	College (1-4or 5+	-)		fessor	,		Edu	catio	n	
70	filed Hygi other ent, II		17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, N	laiden Suri	name)		
yland	ild be fental rked c	To Be	Clark Norton					Jessi	e Ki	rk			
az	shou and N s mai	-	19a. Informant's Name/Relationship (	Type. Print)	198	b. Mailir	g Address (Street a	and Number or Rui	al Route Number,	City or To	wn, State, Z	(ip Code)	
e, Mai	and 2 ealth n 27 i		Mary E. Norton /	Wife			Melfa La				20715		
o e	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	I .		sition (Name of natory or other place		Date 2 /2009		on - City or		
baltimor	t. Pag rtmen rtant: rjury		4 □ Donation 5 □ Other (Specify		Atlant		Crematory	' l '				ie, Maryland ral Home,	
g	permi Depar Impor any ir		21. Signature of Funeral Service Licer	(			. Name and Addres					20715	
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Fina disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or s a	e. けんに a consequence	He of):	er the mode of dyin		or respiratory arre	est,		Approximate Interval Between Onset and Death	
	rted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	: 01).					-1		
<b>-</b>	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence	of):	<del></del>			_			
<b>68/60</b> ,	ate be hysicie he bur	Medical		▶ d									
O. Box 6	eath cer attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal deat		Ectopic pregnancy	у		23d	. Date of de Month	ivery Day Year	
ds, P	requires that neen signed b nould be deta	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the u	nderlying cause give	en in Part I.	23e. Did tot	,		o the cause of death? robably 4 ☐ Unknown	
I Kecords,	The law ate has b page 2 sl	Completed							24a. Was a autops perforr 1 □ Yes	med?	prior to death?	utopsy findings available completion of cause of	
Ital	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?	111			044		th (Check only on				
0	Physical direction	<u>۲.</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	nt 2 ER/C	Outpatier Time o	nt 3 □ DOA Oth	er: 4 ☐ Nursing H	ome 5 Reside			ecify)	
0	ding th. After	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	(,Year)	Injury	Worl	(? Yes 2 ∐No	200. 20001100 110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
DIVISION	or Atten after deal Director. In by the	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e land of Inju	ry - At home, f :. <i>(Specify)</i>	farm, str	eet, factory, office		28f. Location (Si City or Town	treet and N n, State)	lumber or R	ural Route Number,	
_	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funera	edical Ce	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	hysician: To the best of miner: On the basis of and manner sta	examination a	ge, deat and/or ir	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the c rred at the time, d	ause(s) ar	nd manner a ace, and due	s stated. e to the cause(s)	
	To th withir To th	Me	29b. Signature and title of certifier	^			29c. Licens	e number	2	9d. Date s	igned (Mon	th, Day, Year)	
			The state of the s	MD			DZ	4689		Jul	1, 2:	3, 2009	
	6.		30. Name and address of person who	completed cause of de	eath (Item 23a	(Type,	Print)	0 1	Q Q			5, 2009 20716	
	500		31. Date filed (Month, Day, Year)	14999 32. R <b>ø</b> gistra	ttea Hh	Cen	FE-Bric,	Duite	Ca) Do	mil	1000 2	-0116	
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State of Maryland / Department of Health and Mental Hygiene

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Physicia		e <b>gistrar</b> . Decedent's Nam	ne (First, Middle,La	ast)					Mor	e of Death hth Da	y Year	3. Time of Death 0753 hrs	
Medical Examin	er	Christo		Napolita		145	City, Town, or L	ocation of I		25, 2009	4c. County of De		
	4	la. Facility Name ( University h		ive street and number	)		City, Town, or L Baltimore	ocation or i	Doddi				
		5. Social Security I		Sex 7. Ag	je (In yrs. last	t birthday)	If Under 1 Year	If Under		ate of Birth (N		. Birthplace (State or	
Funeral Director		219–84–20	200	<b>X</b> M 2 F	48	Yrs.	Months Days	Hours	Min. J	ul 30,	1960	oreign Mississippi Country)	
any	-	Usual Residence o 10a. State	of Decedent 10b. County		10c. City, T	own or Location						10d. Inside City Limits 1 Yes 2 X No	
and show nce	5	10e. Street and Number								10g	. Citizen of What Country?		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once	Director	De. Street and Number 3300 Breckenridge Way						1140		1.53	USA		
with th ms 23a be noti		11. Marital Status	ried 2 X Marri	12. Was Deceder		13. Was	Decedent of Hist , specify Cuban,	panic Origii Mexican, I	n? ( Specify Puerto Ricar	Yes or No- i, etc.)	14. Race - A White, e	American Indian, Black, etc.	
r death or ite	Funeral			1 Yes	2 X No	1 1 Y	es 2 X No	specify:				White	
5-0036 led within 72 hours after displace. other than "natural", the Medical Examiner.	à	3 Widowed		or Dates: y only highest grade co	ompleted)	16a Docodent's	Usual Occupati	ion (Give k	ind of work d	one 1	6b. Kind of Busin		
72 hou "nat	Completed	Elementary/Se		College (1-4 or		during mos			ise retired)		Joint V		
036 ithin and the same.	d I			44			Presid		Name (Firs	Middle, Ma	Marketi iden Surname)	.119	
15-0036 Tiled within 72 Hygiene. d other than , the Medical			e (First, Middle, La d Napoli						ise Le				
2121 ould be fill Mental I marked ic event,	o Be		Name/Relationship			19b. Mailing	Address (Stree				er, City or Town,	State, Zip Code)	
imore, MD 21 Pages 1 and 2 should ment of Health and Me tant: If item 27 is ma				apolitano/			Brecken				MD 2114	10 City or Town, State	
e, N I and Health item		20a. Method of D	isposition	3 Removal from		Place of Disposit rematory or other	ion (Name of cer er place)	metery,	July	30,			
nor Pages ent of nt: If		1 X Burial 2			Lak		lem. Gar		200		Davidso	onville, MD	
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		21. Signature of	Funeral Service Li	icensee		22 N Har 495	ranco & Gov. R	s of Facility Sons itchi	e P.A.	Seve	erna Par erna Par	ck Funeral Hock, MD 21146	
Physician		23a. Part I. Enter	the disease, or co	omplications that caus	ed the death.	Do not enter the	e mode of dying	, such as c	ardiac or res	piratory arres	st, shock, or hear	t Approximate Interv Between Onset ar	
Viedical		failure. List	failure. List only one cause on each line.  Death  Immediate Cause (Final disease  a. Blunt Force Neck Trauma with Subarachnoid Hemorrhage										
.aminer		or condition resu	ulting in death)	Due to (or as a co									
	Ŀ	Sequentially list		b Due to (or as a co	nsequence of	f):							
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ed nsit	Examine	events resulting		Due to (or as a co	nsequence o	it):							
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed rdeath evtor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	edical	UNPEND	ED	AMENDED									
60, ate be ex hysician e burial	Med	IF FEMALE:		23c. If yes, out	come of preg						23d. Date of o Month	delivery Day Year	
Sox 6876( leath certificate e attending phys for use as the b	Physician/M	23b. Was decede past 12 mor	ent pregnant in the oths?		n t at time of de		tal death 3 her (Specify)	Ectopi	ic pregnancy		WOTET	24,	
Box e death of the attened for us	sic	1 Yes 2	No 9 Unki			5 00	ner (Specify)						
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of Vital Records, ng Physician: The law requir After this certificate has been s meral director, page 2 should 1	B O		eferred to medical					ce of Death	h (Check onl		Residence 6	Other:	
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Division pital or Attendir ours after death leval Director: A	ertification.	3 Suicide	deter	d not be (Specify)		,			33	or Town, S ord Street at	State) nd Atlantic Ave	enue, Ocean City, MD	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director		29a. Certifier		hysician: To the best miner: On the basis of	of my knowle	edge, death occu	irred at the time, ation, in my opini	date and plion, death	place, and du	ue to the caus he time, date	se(s) and manne and place, and o	r as stated. due to the cause(s)	
To th within To th	Modical	29h Signature	and title of certifie	and manner sta	ated	<del> </del>		ense numbe			29d. Date sign	ned (Month, Day, Year)	
	2	M	116	0	MI	)	0.0	C.M.E.			July 26, 20	)09	
1415			address of person Alexander MD	who completed cause D. Assistant Mo	e of death (Ite	em 23a) aminer 11	1 Penn Stre	et, Baltir	nore, MD	21201			
	Stat		Month Day, Year)	1	strar's Signa	ature .	4						
Reg		er	JUL Z	9 2009	known	3.6	an		OUNE				
DHMH 17 Rev	1/200	1		-		ORIGIN	AL		PONE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:30 PM O'Neill Arline C. July 21, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 78 218-24-3777 12/04/1930 Washington, D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 XNo Director Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 448 Cranes Roost Ct. 21 401 USA ms 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel ulth and Mental Hygiene. 27 Is marked other than " r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Teacher County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be Selma Johnston Howard Henry Compton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any injury or other trau once. 21054 Gary Cramblitt / son 2346 Columbine Ct. Gambrills, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 7/23/2009 Bayview Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Ver 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) promode Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√2 No 24a. Was an autopsy performed? Yes 2 No page 2 After this certificate 25. Was case referred to medical examiner? Physician: funeral director, 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No r death. 2 Accident To the Hospital or Attenc within 24 hours after death To the Funeral Director: the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and rule of certify 07,21,2000

Registrar

State

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10015

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2009 GREGORY PAUL PARKS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Medical **Examiner** WICOMI 8 Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1 X M 2 □ F **Funeral** Months Days Hours Min 214-66-7694 54 05/05/1955 VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at 1 X Yes 2 □ No **ACCOMACK** PARKSLEY **VIRGINIA** Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23421 U.S.A. 24330 CHADBOURNE STREET death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: U.S. NAWY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Inmortant: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examinan any injury or other traumatic event, the Medical Examinan and 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT BALLOON SPECIALIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLIFTON HENDERSON PARKS EVA PRUITT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NANCY RUDE PARKS / SPOUSE 24330 CHADBOURNE ST., PARKSLEY, VIRGINIA 23421 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/27/09 SHORE CREMATORY PARKSLEY, VIRGINIA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Willams WILLIAMS FUNERAL HOME, 25046 PARKSLEY RD., PARKSLEY, VA 23421 ofm 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MPFOIG /Medical Due to (or as a consequence of): **Examiner** 2I chen Sequentially list conditions, if any, leading to infirmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year for 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed by 2⊠ No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1'∰Yes 2 □ No 1 ☐ Linpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at After 5 Pending investigation 1 Natural after death. I Director: Af d in by the fur 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide n 24 hours aft e Funeral Di letely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Elimetrical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 24 hor To the Fune completely f ٩

State Registrar

29b. Signature and title of certifier

HearNe 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated

29c. License number

salisbury MO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death YTUL **Physician** 2009 30 MARGARET LOUISE PEARSON 9:55 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY CASEY HOUSE HOSPICE ROCKVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT | 10 Pty | 1922 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F 218-76-9947 86 Director VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a, State 10b. County 1 ☐ Yes 2 No Director MD MONTGOMERY DICKERSON the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22920 MOUNT EPHRAIM ROAD 20842 USA Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Aq Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY EFFIE BURRESS WILLIAM FRAZIER KIDD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troonce. 3769 WALLBACK RD., VALLEY FORK, WV 25285 BETTY DAVIS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2009 MONOCACY CEMETERY BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funral Privio 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a FLUID OVERLOAD disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ATRIAL FIBRILLATION cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed CEREBRO VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica tiely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) To the within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kou eltehou

DHMH 17 Rev 1/2001

State Registrar

KB

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JOCELYNE KOUATCHOU,

31. Date filed (Month, Day, Year)

D6374

MD 6001 MUNCASTER MILL RD., ROCKVILLE,

JULY 30, 2009

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Dep State Ce Registrar Ce	ertificate of Death		.No. 9 9 9 0	90000			
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		Mary Elizabeth Pepper		July	26, 2009	11:53A <sup>M</sup>			
and a	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
			245 Providence Road	Annapolis		Anne Arun	de1			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Y		ace (State or Foreign try)			
	Director		120-14-5858 1□ M 21x F 85 Yrs.		8/4/19		York			
	pu »		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		10	Od. Inside City Limits			
	aryla shov dat	5	,	polis			1 ☐ Yes 2 ☐ No			
	Ba-f	Director	10e. Street and Number	10f. Zip Code	100	Citizen of What Coun	trv?			
	with t			·	109		.,.			
	s 23	Funeral	245 Providence Road  11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (St	pecify Yes or No-	USA 14. Race - Americ	an Indian,			
	item	<u>ا</u> ڌِ.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ □ Ves 2 □ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	etc.			
50	rs af	by	3 Midowed 4 Divorced Year or Dates:	1 ☐Yes 2 No Specify:		Specify: Wh:	ite			
ş	tura atura	ed	15. Decedent's Education 16a. Dec	edent's Usual Occupation		6b. Kind of Business/Inc	lustry			
5	in 72	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of world DO NOT use retired)						
7	y with	mo;		me Maker		Own Home				
<u> </u>	othe vent,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname)				
la l	Ald by Mentgarked rice	To E	Walter A. Law	Ella I	ynch					
ar Z	short s ma		19a. Informant's Name/Relationship (Type. Print)	iling Address (Street and Number or Ru	ral Route Number, 0	City or Town, State, Zip	Code)			
Σ	I and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Madical Exacitinal must be nothind at			Live Oak Drive, M						
e C	of He		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20c armetery, or  A not a many to the commetery, or	position (Name of ematory or other place)		Oc. Location - City or To				
Ĕ	Page nent ant: It		4 □ Donation 5 □ Other (Specify) ATIING LO	n National Cem 8/2	.6/2009   A	rlington,	VA			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinations to any injury or other traumatic event, the Madical Examinations to any injury or other traumatic event, the Madical Examinations to any injury or other traumatic event, the Madical Examinations to any injury or other traumatic event, the Madical Examinations to any injury or other traumatic event, the Madical Examinations to any injury or other traumatic event, the Madical Examination to any injury or other traumatic event, the Madical Examination to any injury or other traumatic event, the Madical Examination to any injury or other traumatic event, the Madical Examination to any injury or other traumatic event.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Jo	hn M. Tay	lor Funera	1 Home, Inc			
n	89 <b>E 8 9</b>			147 Duke of Glouce	ster St,	Annapolis,	MD 21401			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between			
a co	Physician	i								
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Deripheral Vascular disease T  ue to (or as a consequence of):							
	Examiner		I hyperlipio	lemia	years					
	p ±	ner	b. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events				0			
	ocute nd ransi	Examiner	Cause (Disease or injury that initiated events c.							
ó	e exe	m	resulting in death) Last Due to (or as a consequence of):							
68760,	tificate be executed ig physician and as the burial-transit	edical	d							
		Mec	IF FEMALE:							
Box	eath cert attending for use a	Physician/M	23b. Was decedent pregnant  1 Live birth 2 Fetal death	B ☐ Ectopic pregnancy		23d. Date of deliver	ery Day Year			
	the a	Sici	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 9 □ Unknown	5 ☐ Other (specify)						
<u>7</u> .	d by etack	F.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did toba	acco use contribute to t	ne cause of death?			
Š,	The law requires that the death cer ate has been signed by the attendir agge 2 should be detached for use	Ď	1 0 3 3 3 4 3	eare -	1 Xxes		oably 4 🗍 Unknown			
5	requi	ted	Coronary reary as							
ပ္	law lasb	칕	hypert ensien		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of			
=	The cate I	Completed by	<u> </u>		perform 1 □ Yes 2*	ed? death? 1☐Yes	2 🗆 No			
119	cian; ertific	Be	25. Was case referred to medical examiner?		th (Check only one,					
Division of Vital Records,	Physician; r this certific ral director, p		1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpat			nce 6 ☐ Other (Speci	fy)			
ב	ing F	.: 0	27. Manner of Death  1 Natural  1 Natural  28a. Date of Injury (Month, Day, Year)  28b. Time Injury	/ Work?	28d. Describe hov	v injury occurred				
<u> </u>	Attending in death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be 28a Place of Injury - At home farm	M 1 □Yes 2 □No	006 1 10 101	t and Marshan and Pro-	- I Davida Mumbar			
Ž	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Run State)	ai Houte Number,			
	urs a		OOL COME	oth popurred at the time, date and -t	a and due to the	usea(e) and monner as	stated			
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier (Check only one) 1. Titfyling Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	rinvestigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ite and place, and due t	o the cause(s)			
	To the I within 2 To the I complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29	ld. Date signed (Month,	Day, Year)			
	5 × × 5		lla a mala	045297	1	July 27				
			tune 11 way		,	, 1-,	, 2001			
1	1100		30. Name and address of person who completed cause of death (Item 23a) (Typ		D 04 - :					
7	MOU		Elaine Arata M.D. 31 RODINSON ROAG	l, Severna Park, M	D 21146					
	Sta Regist		JUL 28 2009	hadel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:03 P <sup>M</sup> 07 28 2009 Zangwill Posin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Bedford Court Skilled Nursing Home If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**√** M 2□ F 130-14-3248 93 New York Director 07-15-1916 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at YYes 2 ☐ No Director Silver Spring Montgomery the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 3701 International Dr. Apt 217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent 2... Armed Forces? 1∑Yes 2☐No WWII filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give WWII Year or Date 1:944-1945 1 □Yes 2√▼No Specify. Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) atth and Mental Hy. 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be timent of Health and Mentatant: If item 27 is marked Rose Bobb Louis Posin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)2090619a. Informant's Name/Relationship (Type. Print) 3701 International Dr. Apt 217 Silver Spring,MD Pearl Posin / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department of Important: If any Injury or once. 08-12-2009 Paramut, New Jersey New Cedar Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign the of Funer 5 sice Licensen 22. Name and Address of FacilityDanzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** marstire /Medical Due to (or as sonse uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be execute and Due to (or as a consequence of): Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 - Ectopic pregnancy Year Month Day 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) ed by the a Ö 9 Unknown <u>a</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 25 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation after death.

I Director: All in by the fu 1 □ Yes 2 🗌 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in I To the Hospital of within 24 hours all To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Wilkerson Ninala MD.

31. Date filed (Month, Day, Year)

Registrar's Signature

344 University Blvd. W. #113 Silver Spring,MD 20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per DVR G894 8/17/09 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:37P™ Loretta Joyce Perry 24 2009 Ju1y /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Riva Terrace 6 Davidsonville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 03/02/1931 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 21 ☑ F 78 578-36-9535 Director Virginia Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at agree. 10a State 1 ☐ Yes 2 XNo Director Maryland Calvert Huntingtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20639 United States 3290 Soper Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ∭ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Guthrie William Lloyd Bondurant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3290 Soper Road, Huntingtown, Maryland 20639 Terri Lynn Herrick/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 07/27/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of E 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroscurotic Cardiovascular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 🗆 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 No 1 □Yes 2 🗆 No After this certific funeral director, 26. Place of Death (Check only opte) 25. Was case referred to medical Be Assisted examiner's Other: 4 Nursing Home 5 Sestuence 6 Other (Specify) Living 2 No 1 ☐ Yeş 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural n 24 hours after death. e Funeral Director: Af eletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00057465 MSKMapaineMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200, Relyerstown, MD. 21136 N.S. KajupakseMD 25 MAINST Suite

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

32. Redistrar's Signature

2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Mai	ryiand			te of De		Mental Hy	giene Reg. No	711114	2	26066
	Physici	an	1. Decedent's Name	(First, Middle, Last)					11.		2. Date of De Month	eath Da	y Year	3.	Time of Death
	/Medic	cal	Norma 4a, Facility Name (If I	not institution give	Frances				bbins	cation of Deat	<u>  G7</u>	28	. County of Dea	9 <u> </u>	(0.00° M
<b>U</b>	Examin	ier	castal	105000		La	Vo	70.00	al is	5 60	Cy		1 / .		ico
	Funeral		5. Social Security Nu	mber 6. Sex	7. Age		st birthday, Yrs.	) If Under		Under 24 Hrs Hours Min.	Month, D	ay, Year,	)   C	ountry)	(State or Foreign
	Director		222-12-99 Usual Residence of D	40	8	2	IIS.				9-16-	1926	D	elaw	are
	ryland show	<u>.</u>	10a. State	10b. County		10c. City,	Town or L	ocation							nside City Limits
	he Ma	Director	MD	Wicomic	0	Sa.	lisbu		in Codo		7	10a C	itizen of What C		∐Yes 2∭∏No
11	death with the Maryland ms 23a or 28a-f show Linust be nettified at	I Dir	10e. Street and Numb		#112			101. 2	ip Code 2180	1/1		rug. Ci	USA	ountry?	
245	death	Funeral	11. Marital Status		12. Was Decedent Ev Armed Forces?	er in U.S	. 13.	Was Dece			Specify Yes or Note to Rican, etc.)	0-	14. Race - Am Black, Whi		ndian,
VV 3036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Expraine must be rufflied at once.		1 ☐ Never Marrie 3 🏹 Widowed 4	_	1 ☐Yes 2 No If Yes, Give Year or Dates:	•			2XINo S		to Fridain, Gro.)		Specify: W	nite	
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Maryland	should I and Men s marke umatic	ပ	Norman  19a. Informant's Nar	ma/Ralationahin /Tu	no Print)	]	Loflan			lildred	ural Route Numi	nor City		llis	
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ore,	es 1 a of Hea if item or othe		20a. Method of Dispo			20b. Pla			ame of other place)	i	Date		ocation - City o		
	t. Pag tment tant: I		4 ☐ Donation 5	5 ☐ Other (Specify)		Spri			-		-2009		bron, M		and.
Ball	permit. Departr Imports any inju		21. Signature of Fun	iso the	ey Bla	ke	7	05 E.		Street	Bounds l , Salish	oury			21804
					cations that caused the cause on each line									Apr Inte	proximate erval Between set and Death
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	Examiner		0	I	Due to (or as a	consequ	ence or,								
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Ċ,	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) La		Due to (or as a	conseque	ence of):								
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89 ×	certifica ding ph		IF FEMALE:		3c. If yes, outcome o	fprognar	2016								
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent in the past 12 p 1 Yes 9 Unknown	nths?	1 Live birth 2 4 Pregnant at t	Fetal	death 3	☐ Ectopic ☐ Other (s	pregnancy specify)				23d. Date of de Month	elivery Day	Year
rds, P.	w requires that the de s been signed by the a should be detached f	ğ	Part II. Other signific	cant conditions cor	ntributing to death but	not resul	ting in the u	underlying	cause given i	in Part I.			use contribute		use of death?
Division of Vital Records,	hysician: The law re his certificate has ber I director, page 2 sho	Completed									24a. Was auto perf 1 □ Yes	psy ormed2	death?	-	findings available tion of cause of
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of	Phys er this erat dir	: To	1 ☐ Yes 2 ☐ N 27. Mapper of Death		28a. Date of Injury	, T	28b. Time o		OOA Other: 28c. Injury at		Home 5 ☐ Res		Other (Sp	ecity) /	Hospica
ion	ath. r: Afte	atior	Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day,	Year)	Injury	М	Work?	s 2 No					
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injur building, etc.	y - At hor (Specify	ne, farm, st	treet, facto	ry, office		28f. Location City or To	(Street a wn, Stat	nd Number or F te)	Rural Ro	ute Number,
	ie Hospit 1 24 hour ie Funera pletely fill	Medical (			sician: To the best of ner: On the basis of and manner state	examinati									
	To th withir To th comp	Me	29b. Signature and ti	tle of certifier				29	9c. License n				ate signed (Mor		Year)
	6		1		_			_	200	5841		No.	7/29	105	
	JAN.		30. Name and address		empleted cause of de	ath (Item	23a) (Type	, Print)	CALL	sisua	ا ريا	us	7 2	180	2_
	Sta	te	31. Date filed (Month		32. Registrar	's Signati	nra 1	Lake	JAM	Jour	7			,	
	Registr	ar		nn 3120	ng street	v ,	P. 19								

# Raymond W. Ruff

			Please Type or Pri								
		-	For State of M  State Registrar		epartment of H Certificate of I		lental Hygiei Reg.	0000	26067		
*	Physicia	_	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death					
),	/Medic Examin Funeral	30	5. Social Security Number 6. Sex 7. Ag	lity Name (If not institution, give street and number)  ALVER SIDE  ABOUTH SIDE  4b. City, Town, or Location of Death  BELLER SIDE  AMOUNT OF LOCATION							
4	Director		220-20-8407  Usual Residence of Decedent  10a. State 10b. County	10c. City, Town			July 5, 1	920 Mar	yland  10d. Inside City Limits		
	the Maryl 28a-f sho otified a	Director	MD Harford  10e. Street and Number	Bel A	10f. Zip Code		10g.	Citizen of What Co	1 □Yes 2√ No untry?		
136	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturaly" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral Di	6 Corns Drive  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces 1	21015  Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify			ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - Ame Black, Whit			
15-0036	in 72 hou "natura ledical E	Completed	15. Decedent's Education (Specify only highest grade completed)		! Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of work		o. Kind of Business/	Industry		
d 212	filed with Hygiene. other thar ent, the N	Be Com	Elementary/Secondary (0-12) College (1-4or Unknown  17. Father's Name (First, Middle, Last)	5+)	Disabled	18. Mother's Nam	e (First, Middle, Mai	Disab den Surname)	led		
Maryland	should be ind Mental s marked c umatic ev	To B	Raymond W. Ruff			Martha			7: 0: 4:1		
	12 h a		19a. Informant's Name/Relationship (Type. Print)  Myrtle Ruff-Christmas (In-	- 1	Mailing Address (Street Corns Drive				zip Codej		
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21 Signature of Funeral Service Licensee	20b. Place of cemetery	Disposition (Name of y, crematory or other plants & Co. I y  22. Name and Addre  552 Lewis	nc. 08/0 ess of Facility Li	3/2009 Wes	Funeral H	r, PA ome, P.A.		
),	Physician and Medical Examiner sthe private transit	edical Examiner									
.O. Box	the death certificate be r the attending physicia ched for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown		23d. Date of de Month	livery Day Year					
Records, P.	quires that the de n signed by the a and be detached t	b	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause giv	ven in Part I.		oid tobacco use contribute to the cause of death?  ☐ Yes 2☐ No 3☐ Probably 4 ☐ Unknown			
al Reco	: The law requires that the cate has been signed by the page 2 should be detache	Completed	24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No								
. Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa	tient 2 ER/Out	tpatient 3 DOA Oth	or"	th (Check only one) ome 5 Resident	ce 6 □Other (Spe	ecify)		
Division or	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending (Month, December 2) Accident investigation		Time of 28c. Injury Wo	ry at rk? ]Yes 2 □ No	28d. Describe how	injury occurred			
Divis	Hospital or Attende to the saft hours after death Funeral Director: stely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of it building,	njury - At home, far etc. (Specify)	rm, street, factory, office		28f. Location (Stree City or Town,	et and Number or F State)	lural Route Number,		
	le Hospita 24 hours le Funeral oletely filled	edical (	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the besing the properties of the period	of examination and	e, death occurred at the t d/or investigation, in my	ime, date and place opinion, death occu	e, and due to the cau irred at the time, date	se(s) and manner a e and place, and du	is stated. le to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	m	29c. Licen	se number	29d	7/31/09	th, Day, Year)		
			30. Name and address of person who completed cause of	death (Item 23a) (	Type, Print)	racphail	Ad Ba	ed An 1	n 21014		
	St Regist	ate rar	31. Date filed (Month, AUG ar) 5 2009 32. Reg	itrar's Signature	Type, Print)		1.0 11				

		. For	epartment of Health and N Certificate of Death		g. Noo O O	26068				
Physi	cian	1. Decedent's Name (First, Middle, Last)  Rose Harriett SMITH		2. Date of Death Month	Day Year	3. Time of Death 2:01 p. M				
/Med		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August	2, 2009 4c. County of Deat					
Exam	iner	13900 Pennsylvania Avenue	Hagerstown		Washingt	on				
Funera Directo		5. Social Security Number 214-09-7832 6. Sex 1	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Dec. 4,	Year) 9. Birti	nplace (State or Foreign untry) ryland				
and w	7	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits				
Maryla t-f sho fied at	ţ	Maryland Washington Hager	stown			1 ☐ Yes 21 No				
ith the or 28g	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?				
s 23a nust b	erall	13900 Pennsylvania Avenue	21742	posity Voc or No	U.S.A.	rican Indian				
ING 21213-UU35  be filed within 72 hours after death with the Maryland ttal Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates:	<ul><li>13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 X No Specify:</li></ul>	Rican, etc.)	Black, White	e, etc.				
Z15-UU36 hin 72 hours af B. an "natural", or Medical Exam	Completed	(Specify only highest grade completed) (0	Decedent's Usual Occupation  Give kind of work done during most of work  ife. DO NOT use retired)	king	16b. Kind of Business/	Industry				
Baltimore, Maryland 2121 semit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. mportant: If item 27 is marked other than ' my Injury or other traumatic event, the Ma	S	8 0	8 0 small parts assembly aircraf							
iryiand Z should be filed ad Mental Hygi marked other matic event, ti	Be	17. Father's Name (First, Middle, Last)	18. Mothers Nam	e (First, Middle, M Naomi Sh	,					
aryiand 2 should be 1 and Mental I is marked of tumatic eve	우	Ernest DeMotteis  19a. Informant's Name/Relationship (Type. Print)  19b. N	Mailing Address (Street and Number or Ru			Zip Code)				
and 2 s and 2 s ealth ar n 27 is eer trau			McDowell Avenue, H							
Gore, Maryla ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic			Disposition (Name of crematory or other place)	Date 2	20c. Location - City or	Town, State				
Pages ment of ant: If its		4 □ Donation 5 □ Other (Specify) Rest Ha		2009	lagerstown	<del>-</del>				
permit. Page Department of Important: If any Injury of		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	415 East Wilson Blv	d., Hage						
https://www.medicate be executed by https://www.edu.com/medicate be executed by https://www.edu.com/medicate/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/provides/pr	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of Due to (or as a consequence	Y : =	u vere		Immedia				
HECOTGS, P.O. BOX 66/00,  The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	d	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	Day Year				
ires the signed	b	Marine Marine Control of Marine Control	ne underlying cause given in Part I.	23e. Dia tob	oacco use contribute to es 2⊠No 3⊟Pi	othe cause of death? obably 4 Dunknown				
	Completed	7-9-7-17-0-18-1		24a. Was ar autops perform	n 24b. Were at prior to death?	utopsy findings available completion of cause of 2 \sum No				
/Ita	Be	25. Was case referred to medical examiner?		th (Check only on						
on o	2	27. Manner of Death Natural 5 Pending (Month, Day Year)	(Month, Day Year) Injury Work?							
LIVISION OF Hospital or Attending Phys 4 hours after death. Funeral Director: After this tely filled in by the funeral di	Certification:	Accident investigation    Accident   Acciden								
To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.								
To the I within 2 To the Complet	Me	≥ 29b. Signature and title of certifier  ► Way & Way & O-	29c. License number 0 2 3 8 / 5		9d. Date signed (Mont	09				
2-Hc		30. Name and address of person who completed cause of death (Item 23a) (T Wary E, Money, M), 35	ype, Print), 4 Will St., Ha	gersto	un, un	21748				
S Regis	state strar	31. Date filed (Month AUGY 5 2009 32. Resistrar's Signature	pare							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0901 M **Physician** BARA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 30 Wilelinor Drive Anne Arundel Edgewater 5. Social Security Numb If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Funeral Year) Months Days Hours Min. 1 M 2 F 277-42-64<del>94</del> 62 6-6-1947 Ohio Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r items 23a or 28a-f show item wat be rutified # 1 □Yes 2X1No **Funeral Director** Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Wedgall Eversities I was been once. 30 Wilelinor Drive USA 21037 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ऒ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No If Yes, Give Year or Dates: Specify ģ Specify: 3 ☐ Widowed 4 🄀 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) 12th Legislature <u>Administrative Assistant</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Cox Katherine Foley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Douglas J. Bernia/Life Companion 30 Wilelinor Drive, Edgewater, Maryland 21037 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Kalas Crematory 7/23/09 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home WWW 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death YDaw 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificata be executad physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the functional director, page 2 should be detached Q | | | Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranter stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print). ne and address of person 10 11CHA W 31. Date filed (Month, Day, Year) 32 State **JUL 24** Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Day **Physician** Edwin Robert Siemasko /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boult more washington medical Center Burnie ar I If Under 24 Hrs. Anne 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1.□ M 2□ F Months Days Min 87 7/22/1922 **Director** 186-14-1015 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director Edecin MD Anne Arundel Jessup 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 2723 Annapolis Road 20794 items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 43-4 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 'natural", or 1 ☐ Yes 2 XNo Specify: White Specify. 2 Siemasko 3 Widowed 4 □ Divorced 43-45 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 2 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Foreman Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Siemasko Helen Wronoski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r Item 27 is <u> Michael Siemasko (Son)</u> 2033 Pinecroft Ct. Odenton, MD 21113 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Vet. Crownsville 7/29/2009 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. any 851 Annapolis Rd. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its agents. Examiner Due to (or as a consequence of) Hospital or Attending PhysIclan: The law requires that the death certificate be executed tran that initiated events resulting in death) Last -burial-1 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical nding p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page perform certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient ပ 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 া Naturai 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

2009

Arunde

PA

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

3 Probably

29d. Date signed (Month, Day, Year

Year

4 Unknown

1 ☐ Yes 2X No

State

To the

Medical

(Check only one)

29b. Signature and title of certifier

reovae 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

2009

32. Registrar's Signature

The

DHMH 17 Rev 1/2001

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2009 9:30 P M August Schlossnagle Annabelle 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 109 Oak Hall Drive 0akland Garrett If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 212-24-0643 March 11, 1927 West Virginia 82 Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 No Garrett 0akland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 109 Oak Hall Drive United States 21550 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2X No Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Offutt Oliver Kisner Millie A. Sisler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 Cherry Lane, McHenry, MD 21541 J. Terry Schlossnagle, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4/2009 Oakland, MD Oakland Cemetery Name and Address of Facility David A. Burdock Funeral Home, P.A. N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vears UNG disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IE EEMALE

**Physician** /Medical Examiner

**Physician** 

Examiner

Funeral

Director

ns 23a or 28a-f show

"natural", or item

7 is marked other than "natu traumatic event, the Medical

Director

Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.

t of Health a permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tr. once.

Baltimore, Maryland 21215-0036

/Medical

Examiner burial-trar attending physician for use as the burial Physician/Medical been signed by the should be detached þ Be Completed s certificate has b lirector, page 2 sl after death.

Director: After this certific Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year					
Part II. Other significant conditions	contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  No 3 Probably 4 Unknown					
			24a. Was an autopsy performed? 1 □ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 ☐Other (Specify)					
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	hysician: To the best of my knowledge, death occu iminer: On the basis of examination and/or investig and manner stated.								
20h Signature and title of certifier		29c. License number	29d Da	ate sidned (Month. Dav. Year)					

State Registrar

m.D. Jar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG

29b. Signature and title of certifie

30. Name and address of person who compl

4+hSt Oakland

ed cause of death (Item 23a) (Type, Print)

within 24 hours aft To the Funeral Di completely filled in

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month W Edward Schirmer 2009 12:10 AM July 24, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Convelesant Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav 1 X M 2 ☐ F 289-26-8228 77 May 18. 1932 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d Inside City Limits 1 Dres 2 No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 Tarleton Way 21114 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 M Married 1 □Yes 2 No Specify. White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Navy Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Anthony Schirmer Catherine M. O'Donnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Schrimer/ Wife 1709 Tarleton Way Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/28/2009 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service 16000 Amnapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Colon Cancer xears Sequentially list conditions, if any pair is the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last David to (Snas a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗆 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

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"naturai"

item 27 is marked other than "nature other traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event and once."

**Funeral Director** 

Completed by

Be

2

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examiner by Physician/Medical Completed Be Certification: To

I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-tran the as use a detached funeral director, page 2: the

Division of Vital Records, P.O. Box 68760, completely filled in by within 24 hours a

30. Name and address of person Pau

29a. Certifier

29b. Signature and title

State Registrar

Medical

32. Registrar's Signature

and manner stated

who completed cause of death (Item 23a) (Type, Print)

D 0029571 07/27/2009 Peferse Hny, Crofton MO21114

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 7.45 aM 29 2009 July Bong Yul Sohn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Silver Spring 2048 Middle Bridge Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Year) Days Hours Months Min 82 Yrs 224-29-6366 August 25, 1926 Maryland Director Usual Residence of Decedent Maryland 10d. Inside City Limits 3a or 28a-f show 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 K No Director Maryland Silver Spring Montgomery the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with ral", or items 23a Examiner must t 20906 U.S.A. 2048 Middle Bridge Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after and thealth and Mental Hygiene. 1 ∐Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: \$ er than "natural", the Medical Exa 3 → Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home O 7 Is marked other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Woo Dae Kang ပ Tk Whan Won 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2048 Middle Bridge Drive, Silver Spring, Maryland 20906 Department of Health Important: If item 27 any injury or other to once. Ki Young Sohn - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 08/01/2009 Olney, Maryland Norbeck Memorial Park 22. Name and Address of Facility 21. Signature of Funeral S wife Lyenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Melanoma (Cancer) of the Urethra 10 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Examir sician and burial-tran Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐Yes 2 🗷 No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has bage 2 s autopsy performe certificate 2 No 1 ☐ Yes 2 X No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 X No မ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 🗷 Natural 5 Pending investigation 1∐Yes 2∐No 2 Accident after death Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours aft the Funeral Di mpletely filled in Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2.

To the F
complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0021033 July 29, 2009

Registrar
DHMH 17 Rev 1/2001

State

Byoung Ki Lee, M.D., 13000 Georgia Avenue, Silver Spring, Maryland 20906

32 Registrar's Signatul

30. Name and address of person who completed cause of death (Italia and Type, Print)

31 2009

31. Date filed (Month, Day, Year)

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 29 Our /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Jennett-Roda NI VOLOV 191 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Funeral 1**№**M 2□ F Year) 336283656 Director 29 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits . 28a-f sh notified 1 Yes 2 No Director MO Garred 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or. any Injury or other traumatic event, the Medical Examiner must be nonce. 627 Hamill Street 21550 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) laborer County Roads Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salem Shreve Rosie Armantrout 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Eugene Shreve/son 171 Beckman Lohr Road, Swanton, MD 21561 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 08/11/2009 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery Oakland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine Du 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of act line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 □ Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 14 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home After this 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 □ No nin 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of entifier 29d. Date signed (Month, Dav. Year)

State Registrar 255 North 4th Street, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Sotiere Savopoulos,

31. Date filed (Month)

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		Registrar				Ceruii	cate of t		2. Date of De	Reg. No.		3. Time of Death
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ite, INTAILY INTAILY ALL INTONOSO stand 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. other Tris marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to rollified.	욘	19a. Informant's Name/Relations	-		19b.	Mailing Ad	Idress (Street	and Number or Ru			wn, State, Zip	Code)
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Dallilliole, Inc permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any Injury or other trai		20a. Method of Disposition	10 / 1141	bana	20b. Place of cemeter				Date		on - City or To	own, State
allillor rmit. Pages spartment of portant: If it y injury or o		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		rom State				i	31/2009	Frede	rick	Maryland
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Darmit permit Depar Impor any fr		1- July	ALLEN	NIK		Stau	offer F	Guneral H Sumtown P	omes P.	A. ederick	MD :	21702
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications the	nat caused th	ne death. Do r	not enter th	e mode of dyi	ng, such as cardia	c or respiratory	arrest,	., 115	Approximate Interval Between
District	i i	shock, or heart failure. List Immediate Cause (Final										Onset and Death
Physician /Medical		disease or condition resulting in death)	d		consequence		liovasc	ular Dis	ease			
Examiner				3 10 (0) 23 4	consequence	,,,						
	e	Sequentially list conditions,	b. Du	e to (or as á	consequence o	of):						
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
exectan an an rial-tr	Exa	resulting in death) Last	Du-	e to (or as a	consequence	of):						
of ou, cate be executed chysician and the burial-transit	dical		d									
rtiffice ng ph as th	/led	IE CEMALE.				_						-
box oc leath certifice attending ph	N/NE	IF FEMALE:   23b. Was decedent pregnant	23c. If yes	, outcome o	f pregnancy	3 □ Ec	opic pregnan	cv		23d.	Date of delive	rery Day Year
The att	sici	in the past 12 months? 1 ☐ Yes 2 🏿 No	4 □ 1		ime of death		ner (specify) _				MOHIT	Day Tour
The law requires that the death certific are has been signed by the attending page 2 should be detached for use as a	Physician/Me	9 Unknown							an- Fid		andelbudo to t	the cause of death?
S, se that igned be de	by F	Part II. Other significant conditi	ons contributing	to death but	not resulting ir	the under	ying cause gi	ven in Part I.				
Hecords,  ne law requires to has been signed ge 2 should be o									1	Yes ZIN		bably 4 Unknown
as be	ple								24a. Was	opsy	prior to co	opsy findings available ompletion of cause of
The ate h	Completed								perf 1 ∐ Yes	ormed? 2 No	death? 1 □Yes	2 🗆 No
VISION OT VITAI MEN Attending Physician: The law r death. ector: After this certificate has by the funeral director, page 2 v	Be (	25. Was case referred to medica examiner?	<u> </u>						ath (Check only	one)		
OT V Physic rthis co	10	1⊠ Yes 2 □ No	Hospital:	1 🗌 Inpatien	t 2 ☐ ER/Ou		LOA		Home 5 🖾 Res			ify)
ng Pl	ü.	27. Manner of Death 1 X Natural 5 ☐ Pendi		Date of Injury Month, Day,		Time of njury	28c. Inju Wo		28d. Describe	how injury oc	curred	
VISION Attending or death. ector: Afte	cati	2 ☐ Accident invest	igation					]Yes 2□No				
vr Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 28e. F	Place of Injur ouilding, etc.	y - At home, fa (Specify)	rm, street,	factory, office		28f. Location City or To	(Street and N own, State)	umber or Rui	ral Route Number,
urs af									l and do had		d monnos oo	abata
Hosp 24 hou Fune tely fi	ical	29a. Certifier 1 ☐ Certifyi (Check only 2 ☑ Medica one)	I Examiner: On	the basis of	examination ar	e, death oc nd/or invest	igation, in my	time, date and place opinion, death occ	curred at the time	e, date and pla	ice, and due	to the cause(s)
DIVISION OF VITAL IN within 24 hours after the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29b. Signature and title of certific		manner stat	ou.		29c. Licen	se number		29d. Date si	gned (Month	, Day, Year)
5 × 5 0	-	100. 7	11.		MDD	MI	-			т., 1	20 0	000
		30. Name and address of person	Lave	22 /	ath (Itom 23c)	(Type Drin		37197		July	30, 2	009
KB								derick, M	[arvland	21701		
Sta	to	Alan Rohrer, M	) אוינע ע	32. Registra	r's Signature	1	FIE	TI CALLER	ary ranu	21/01		
Registr		JUL 3:	2009	Dun	's Signature	pa	Kel					

DHMH 17 Rev 1/2001

			State of Maryland  1 - State Registrar		rtment of H <i>tificate of L</i>			iene eg. No.2 0 0 9	26076
			Decedent's Name (First, Middle, Last)				2. Date of Deat	th	3. Time of Death
	Physicia /Medic		Harold Taylor				July	25° 20°0°9	10:05A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	th
7			Anne Arundel Medical Cente		Annapo	lis		Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F 7. Age (In yrs. Ia	st birthday) _ 7 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Apr 21	<sup>Year)</sup> 1938 Ma	thplace (State or Foreign buntry) ryland
	0		Usual Residence of Decedent						Land to the O're Live're
	show	_		Town or Loc	ation				10d. Inside City Limits 1X Yes 2 □ No
	8a-f	Directo	2	napol:				0.00	**
7	Men T	Ę	10e. Street and Number		10f. Zip Code	2	'	0g. Citizen of What Co	ountry ?
	is 23	eral	140 Conley Dr.  11 Marital Status 12. Was Decedent Ever in U.S.	13 W	2140		ecify Yes or No-	14. Race - Ame	erican Indian.
	riter riter	Funeral	Armed Forces?  1 □ Never Married 212 Married 1 □ No			ispanic Origin? (Span, Mexican, Puerto	Rican, etc.)	Black, White	
2-003p	n / 2 nouls aner deam with the maryland "natural", or Items 23a or 28a-f show cilcal Exstrict must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1960.	-66 <sup>1</sup>	□Yes 2 <b>X</b> No	Specify:		Specify: B	lack
		Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup	ation during most of work d)	ing	16b. Kind of Business	/Industry
<u> </u>	Hygiene. Hygiene. other than "	ם	Elementary/Secondary (0-12) College (1-4or 5+)					MVA	
N -	al Hygie other i		12th 0	שט	<u>cument</u>	Examine: 18. Mother's Name			
	d ber	To Be	Upton Thomas			Minerva	V. Ta	ylor	
<u> </u>	ges I and z should be lifer it of Health and Mental Hyr if frem 27 is marked othe or other traumatic event,	Ĕ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	g Address (Street	and Number or Run	al Route Numbe	r, City or Town, State, .	Zip Code)
	Tand 2 Health a tem 27 is other trai		Beverly Taylor(Wife)	140	Conley	Dr. Ann	napolis	, Md. 21	403
	of He		20a. Method of Disposition 20b. Pl.	ace of Dispos metery, crem	sition (Name of atory or other place	re)	Date	20c. Location - City or	Town, State
Ē,	ant: If		1 Di Burial 2   I Cremation 3   Hemoval from State		d Veter		0-09	Crownsvi.	lle, Md.
balti	permit. Fages I am Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee					ary, P.A s, Md. 21	
			Javry B. Roese MODY83						Approximate
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	DO HOT CITE		- / /	or reophatory an	00.,	Interval Between
	hysician /Medical		disease or condition resulting in death)  Due to (or as a consequ	nap	4 61	mboli			19 days
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Ď,	w requires that the death entitleate be executed to be executed to be signed by the attending physician and should be detached for use as the burial-transit	E	resulting in death) Last Due to (or as a consequ	ence of):				/	
09/90	phys the	edical	d						
×	nding nding se a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. Date of de	elivery
מׁ מֹ	e atten	Physician/M	in the past 12 months?		Ectopic pregnanc Other (specify)	у		Month	Day Year
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s,	ine law requires that the ate has been signed by th bage 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resu	ting in the un	derlying cause give	en in Part !.		bacco use contribute t	
ecords,	een s		- right renian				1 200	es 2 No 3 P	Probably 4 Unknown
ec.	2 38 8	Completed					24a. Was a autop	sy prior to	utopsy findings available completion of cause of
		ပ်					perfor 1 □ Yes	2 No 1 Ye	s 2□No
VITa I	sician: The law certificate has b irector, page 2 sl	Be	25. Was case referred to medical examiner?		Oth	26. Place of Deat			
5	ding Pnysician; The h. After this certificate h. funeral director, page	1: To	27. Manner of Death 28a. Date of Injury	28b. Time of	t 3 LI DOA   5 miles	4   Nursing Ho		ence 6 Other (Spe ow injury occurred	ecify)
ם י	th. : Afte : fune	ţi	Natural 5 ☐ Pending (Month, Day, Year) ☐ Accident investigation	Injury		kí? Yes 2 □No		. ,	
UIVISION	or Attending Proystotan: after death. Director: After this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At homological building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or R	Rural Route Number,
5	irs aft rai Di	Cer							
	one nospiral or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fun	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	n occurred at the till vestigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time,	cause(s) and manner a date and place, and du	as stated. le to the cause(s)
	vithin To the	Me	29b. Signature and title of certifier		29c. Licens	e number	:	29d. Date signed (Mon	th, Day, Year)
			> Shawn MMesses / UNL	)	D12	586		7/27/09	7
1	6:1		30. Name and address of person who completed cause of death (Item	23a) (Type, F	Print)	51-12	01-	110 500	rema Park NO 21146
th.	176		Sharm M. Messics/MO &	5 21 6	w, oer	THE P	dy Sui	Keg 13	no 21196
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signat	A. 1	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month **Physician** 910 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 91 August 3, 1917 Florida Director 578-32-2330 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is investing to purify the Once. 1 □Yes 2\tag{X}No Davidsonville Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21035 1041 Sugar Maple Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 □Yes XXNo Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) High School Teacher Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Estelle Thorn Walter A. Von Wald 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1041 Sugar Maple Drive, Davidsonville, MD 21035 Mary E. Toffolo-Cresce/Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Resurrection Cemetery 8/1/2009 Clinton, Maryland 4 Donation FI Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a/Part1. Epoer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other-significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

29c. License number

Pate signed (Month, Day, Year)

neleted cause of death (Item 23a) (Type, Pring Name and address of p

31. Date filed (Month, Day,

29b. Signature and title of certifie

and manner stated.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** George Albert Wagner, Sr. HUGUST 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Min. Months Hours 1 🕱 M 2 🗆 F 214-09-0053 95 May 19, 1914 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location Show ir than "natural", or Items 23a or 28a-f sho The Medical Examiner must be notified at 1XYes 2 ☐ No Director Maryland Washington Hagerstown 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21742 USA 1470 Lindsay Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Exercises once. 1 Myes 2 No If Yes, Give Year or Dates; 1942–45 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. \$ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) truck mfg. inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ignatius Wagner Mary Knodle 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Genevieve A. Wagner - wife 1470 Lindsay Lane, Hagerstown, Maryland 21742 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 8/5/09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Maryland 21740 415 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as consequence of) P.O. Box 68760, physician Physician/Medical attending physical for use as the b 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No ned by the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, I 25. Was case referre medical examiner? Be 26. Place of Death (Check onle one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number aubetin 3+ HAG MD 21740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIAD TOWN MD 5H-6+1 31. Date filed (Month Car Year). 2009 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 06 (V) M **Physician** ALSIN DWARD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel Harwood Mandrin Hospice House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 29 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Washington, DC 1**Z** M 2□ F , 1931 78 577-42-0389 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Pedical Examplement to inclified at once. 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Shady Side 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20764 1229 Linton Lane Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 MYes 2 □ No If Yes, Give 1951–1953 Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) US Navy Cartographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valentina Ankanbrend Joseph Walsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington, DC 20007 2456 39th Street Josephine Walsh/Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 27,2009 West River, MD Our Lady of Sorrows 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 905 Galesville Road Galesville, MD 20765 23a Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirck, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm die te Causa (Final disealle or condition resulting in death) Neu **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of) Box 68760. Physician/Medical the attending p for use as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a Ö 9 Unknown 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page After this certificate I 1 ☐ Yes → No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other Specify On W Hospital: 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending 1 Natural 5 Pending House 2 🗆 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier ame and address of peoon who completed cause of death (Item 23a) (Type, Print) MA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 09-06090 Tir

mothy Allen V	Velo	Please Type or Print in Black In State of Maryland / Dena	idelible Ink. Ensure All artment of Health and Me		ole.
		4 5 6 4	rtificate of Death	Reg. N	2009 2608
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
edical Exam	iner	Timothy Allen V	Welch	Month Da August 5, 200	09 Year 0130 hrs
		Facility Name (if not institution, give street and number)     Garrett County Memorial Hospital	4b. City, Town, or Location  Oakland	n of Death	4c. County of Death
Funanal		5. Social Security Number 6. Sex 7. Age (In yrs. I		des 24ther 10 Deta - ( District	Garrett
Funeral Director			Months Days Hou	irs Min	MM/DD/YYYY) 9. Birthplace (State or Foreign
	1	220-88-0310 1 X M 2 F Usual Residence of Decedent	43 Yrs.	8/6/19	65 Country) MD
any			Town or Location		10d. Inside City Limits
nd show		MD Garrett	Mt. Lake PArk		1 X Yes 2 No
the Maryland a or 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
the h	늅	197 Oak St.	21550		U.S.A.
N N	Funeral	11. Marital Status 12. Was Decedent Ever in U			14. Race - American Indian, Black,
r deat or ite	臣	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexica		White, etc.
2 hours afte "natural", Examin <u>er</u>	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specif		Specify: White
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Giv during most of working life. DO NO		b. Kind of Business/Industry
336 thin 7 than	힐	12	Construction		Laborer
5-00 ed wi fygier other	5	17. Father's Name (First, Middle, Last)	<u> </u>	er's Name (First, Middle, Maid	
be fill brinked rent,	å	Russell LeRoy We	elch Sr. Pa	atricia A	Ann Stemple
Baltimore, MD 21215-0036 permit. Pages I and 2 should be flied within 72 hours after death Department of Health and Mental Hygiene Important: If item 27 is marked other than "matural", or item injury or other traumatic event, the Medic I Examiner must.	₽	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and No		
md 2 salth a		Kathleen Welch/ Wife  20a. Method of Disposition	809 Q St. Mt.		
Ore			Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or Town, State
tim t. Pag tment rtant:	3		ountryside Crem.	. 8/8/09 I	Davidsville, PA
Bal permi Depar Impo injury		21. Signature of Funeral Service Licensee	22. Name and Address of Facil	<sup>lity</sup> Newman Fur	neral Homes P.A.
Physician	- 10	23a. Part I. Enter the disease, or complication to the carded the death	1203 S. Secon	nd St., Oakl	Land, MD 21550 shock, or heart Approximate Interval
/Medical		failure. List only one cause on each line.			Between Onset and Death
<sup>-</sup> xaminer		Immediate Cause (Final disease or condition resulting in death)  a.   Concentric I  Due to (or as a consequence or condition resulting in death)	eft ventricular hy	pertrophy	Death
		Sequentially list conditions, b.			
	iner	if any, leading to immediate Due to (or as a consequence or cause. Enter Underlying Cause	f):		
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or	f):		
ecuted and transi		d			
be exestician	dical	X UNPENDED X AMENDED #2 as n	oted, 23a,27,per M	E g899 1/8/10	TT
i, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delivery
x 68 h certi endin use as	ciar	past 12 months?  4 Pregnant at time of de		pic pregnancy	Month Day Year
BO)	hysi	1 Yes 2 No 9 Unknown 9 Unknown	other (specify)		
P.O. es that the igned by	by PI	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in F	Part I. 23e. Did tobac	co use contribute to the cause of death?
S, P uires t n sign Id be c				1 Yes 2	No 3 Probably 4 Unknown
Vital Records, ysician: The law require his certificate has been si director, page 2 should b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Rec The la	Eo			performed	
ian:	Be C	25. Was case referred to medical examiner?		h (Check only one)	
Division of Vital ral or Attending Physician: rs after death.  al Director: After this certifed in by the funeral director	2	1 Yes 2 No Hospital 1 Inpatient 2 🗸	ER/Outpatient 3 DOA Other	Nursing Home 5 Res	idence 6 Other:
n of ding Ph After t funeral		27. Manner of Death  1 X Natural 5 Position 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Wo	_	injury occurred
ivisior for Attend after death Director: I in by the	catio	2 Accident Investigation	1 Yes 2		
Divi	Certification:	determined (0	ome, farm, street, factory, office building,	etc. 28f. Location (Stree or Town, State	et and Number or Rural Route Number, City
Di ospital I hours a uneral I		4 Homicide (Openin)			
Division of Vital Records, P.O. Box 68760, To the Hospital or certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only one) 2 Medical Examiner: On the basis of examination at	je, death occurred at the time, date and p nd/or investigation, in my opinion, death of	place, and due to the cause(s) occurred at the time, date and	and manner as stated. place, and due to the cause(s)
To To con	Mec	and manner stated.  29b. Signature and title of certifier	29c. License numbe		d. Date signed (Month, Day, Year)
		11.1 11-11.	O.C.M.E.	OCIME	ugust 5, 2009
		30. Name and address of person who completed cause of leath (Item	τ Δ.		
		Theodore M. King, Jr., MD. Assistant Medical E	,	altimore, MD 21201	
	ate	31. Date filed (Month Day, Year) 2009 32. Registrar's Signatu	re A A A		
Regist	trar	ANUIS IL IV KUUS Degree	B. Barlet		

DHMH 17 Rev 1/2001

ORIGINAL

For AMEND#18, 2015 per FIFS tate of Maryland / Department of Health and Mental Hygiene State Registrar 8/7/09 AACO HEALTH DEPT. CMH. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:30 AM LosiecHowicz DUCA UAIDDID 24, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner IBOUUSA UUA BURNIE BUCTIMORE-WISHINGTON MEDICAL CENTER CLEH Birthplace (State or Foreign Country)
 New York Social Security Number Date of Birth (Month, Day, Funeral Year) Days 1 □ M 2 🕱 F 093-14-5544 85 Oct. 29, 1923 **Director** Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 28a-f show or other traumatic event, the Wadical Evanithm hust be notified at Glen Burnie 1 ☐ Yes 2 TNNo Director Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 21061 7975 Crain Highway S. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? than "natural", or Items 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: ģ, 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker **Home** 12 should be filed w h and Mental Hygiei is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any Injury or other trainment Andrew Van Bussum Anna Schmitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Daugard/Daughter 330 Overcup Court Millersville, MD 21108 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date TIN 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/5/09 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
Rarranco & Sons, P.A. Severna Park Funeral Home hom 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE VAQ 1 /Medical Due to (or as a consequence of) Examiner 2 PAG 2 AIMOHUBUS Sequentially list conditions, Examiner It any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last execute and Due to (or as a consequence of): burial-Box 68760 attending physician certificate be Physician/Medical the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ■ No 3 Ectopic pregnancy Month Dav Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. \$ COROLLRY ARTERY DISEASE 1 Tyes 2 No 3 Probably 4 Nuknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 X Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OH cosolding gest envergence 40 11553000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLEW BURNIE, MD 2016 1 CHILLERMO DOSE CIANCRECO 31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

**JUL 29** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** Erscel Leoda Younkins August 3, 2009 12:55 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2**X** F 87 Maryland April 18,1922 Director 216-14-5760 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 200No Director Maryland Washington Fairplay 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21733 USA 18016 Lappans Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dress Manufacturing Presser 8 and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Crampton Harvey Myers Fannie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum Patricia A. Hines - Daughter 18016 Lappans Rd. Fairplay, MD 21733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2-4 □ Dopation 2 Cremation 3 DRemoval from State 8/4/2009 5 Other (Specify) Mt. View Cemetery Sharpsburg, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Sign ture of Funeral Ge Williamsport, MD 21795 425 S.Conococheague St. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final oral cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 XUnknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 No page 2 certificate 1□ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director; the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 式 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 00006116 8/3/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown (MD) 05H- 2 STREET, 31. Date filed (Month, Day, Year) AUG 0 4 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year PM **Physician** 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner saltin Rock ure 8411 9. Birthplace (State or Foreign Country)
South Caroline If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 2 Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Its Medical Exprender must be netfilled at 1 Yes 2 □ No Funeral Director more 10f. Zip Code 10g. Citizen of What Country? et and Number 10e. Stre Apti rove Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 🏋 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ၉ Informant's Name/Relationship (Type. Print) aughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Department of Health an Important; If item 27 Is any Injury or other trau once. 20c. Location - City or 20b. Place of Disposition (Name of pemetery, crematory or other Date 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 22. Name and Address of Fallity
JOSEPH RUSS
2272 W. North re of Funeral Service Licensee 21. Signatu ver Ba Avei 23a. Part/ Emer the disease, or complications that caused the death. Do not enter the mode of pring, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) **Physician** Toge /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of) physician ar s the burial-t Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♣ No 5 ☐ Other (specify) Pregnant at time of death P.0. certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Invursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type\_Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

2009

09-0			Please Type or Print in Black Indelible Ink. Ensure All Co	opies Are Legible.	
Ciya	e A. Adams		State of Maryland / Department of Health and Mental 1-For State Certificate of Death	Reg. No. 2009 250	8
Med	Physicia lical Exami	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death  Month Day Year August 8, 2009  3. Time of Death 1500 hrs	
			4a. Facility Name (if not institution, give street and number)  1358 Walker Avenue  4b. City, Town, or Location of D  Baltimore	f Death 4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2  Months Days Hours 1	Min Foreign A /	
	Director		$215-66-2012$ $1\times M$ $2 = F$ $54$ Yrs.	July 9, 1935 Country) IVI d.	_
۵	nd show any ce,	_	10a. State 10b. County A 10c. City, Town or Location Baltimore	10d. Inside City Limit 1 X Yes 2 N	
4-17	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 10 2 2 9	10g. Citizen of What Country?	
1	r death with th or items 23a	Funeral C	11. Marital Status 1 Never Married 2 Married Armed Forces?  1 Never Married 2 Married Armed Forces?  1 Never Married 2 Married Armed Forces?	in? ( Specify Yes or No- Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	_
	after dea al", or it iner mus	by Fur	3 X Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No 1 Yes 2 X No specify:	specify: Black	_
	72 hours n "natur al Exami	ompleted t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	(ind of work done use retired)	
	5-0036 led within 7 Hygiene. other than	Comp	17. Father's Name (First, Middle, Last)  18. Mother's	s Name (First, Middle, Maiden Surname)	,
	21215 nuld be file Mental H marked c	o Be (	James Bankins  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number)	anche Adams  and Rural Route Number, City or Town, State, Zip Code) 2/2/4	10
	MD 2 nd 2 shou alth and ? m 27 is r	۲	Ms Shantanese Johnson 13253 Carls 1 20a. Method of Disposition (Name of cemetery,	Wood Circle Batto, Md.  Date 20c. Location - City or Town, State	7
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		aromatany or other place)	8/18/2009 Dwings Mills M	la
	Baltin permit Departm Importa Injury o		21 Signature of Funeral Service Licenseer  22. Name and Address of Facility  O See on L. Russ	S. Funeral, Home, P.A.	
	Physician /Medical		23a/ Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	ardiac or respiratory arrest, shock, or heart  Approximate Interv.  Between Onset ar  Death	
	xaminer		Immediate Cause (Final disease or condition resulting in death)  a Narcotic Intoxication  Due to (or as a consequence of):		
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	ed sit	Exami	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		_
	e execute cian and rrial - tran	dical	X UNPENDED 23a,P11,27,28a-f, G894 8/31	1/09 TT	
	ision of Vital Records, P.O. Box 68760,  Attending Physician: The law requires that the death certificate be execute reath recor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - tran	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p	23d. Date of delivery c pregnancy Month Day Year	
	Box (e death ce the attence of for use	Physici	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		
	P.O. es that the igned by be detach	ē	Cocaine use	art I. 23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknow	n
	ords, w requir as been s	Completed		24a. Was an autopsy performed? 24b. Were autopsy findings availa prior to completion of cause of death?	
	I Rec n: The la tificate h or, page 2	e Com		1 Yes 2 No 1 Yes 2 No	_
	of Vital Records,  ng Physician: The law requir  ther this certificate has been is meral director, page 2 should I	To Be	examiner? Hospital: 1 Insertion: 2 ER/Outpatient 3 DOA Other	Nursing Home 5 Residence 6 ✔ Other: Scene  k? 28d. Describe how injury occurred	
	O 1 4 1 9	ation:	1 Natural 5 Pending Investigation Fd 8/8/09 Fd 2:57 pm 1 Yes 2 X to 1	No unk	_
	Division  Hospital or Attendin 24 hours after death Funeral Director: A	Certification:	3 Suicide 6 X Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.	tc. 28f. Location (Street and Number of Ryral Route Number, Corrown, State) 1358 Walker Ave Baltimore, MD	ity
T.	Divi	dical C	293. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one)  7 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)	
10	) o # .o uo	1 6	and manner stated.	les sui la lata a sui i	_

111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner State 31. Date filed (Month, Day, Year)
Registrar

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

original

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 4:30 Αм **Physician** August George Kenneth Atwell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Phoenix Baltimore 6 Overshot Court 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 2, 7. Age (In yrs. last birthday) 5. Social Security Number Min. **Funeral** Hours Months Days Pennsylvania 1 ★ M 2 □ F 68 203-30-6060 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Expraints manned to restrict 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No **Funeral Director** Phoenix Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21131 6 Overshot Court 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married white 1 □Yes 2 X No Baltimore, Maryland 21215-0036 Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cavanaugh Press CE<sub>0</sub> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Mae Neel Smith Atwell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 Overshot Court; Phoenix, MD 21131 Donna Rae Atwell 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othe (Specify) en tombment Dulaney Valley Mem Gardens: 8/18/09 Timonium, MD 22. Name and Address of Facility ic Aigense 1050 York Road 21. Signature of Funeral Ser Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a pleasing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 L/No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0032453

Registrar

State

9 Schilling Road; Hunt Valley, MD 21031

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

111121

Mark Lamos, MD
31. Date filed (Month, Day, Year)

AUG 1

#### 09-06258

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Richard Alde	1	Sta - For State legistrar	ate c	of Maryla	and /				Health Death	and	Menta	al Hyg		eg. No.	20	0 (	9 2	608
Physician Medical Examine	1	I. Decedent's Name (First, Middle John Richard A		1					_				Date of Dea Month August 10	Day	Year )9	1	3. Time of De 17 <b>45 h</b> r	
	4	4a. Facility Name (if not institution 8931 Footed Ridge	n, give	street and nu	ımber)			41	b. City, To		ocation of			4	c. County of I Howard	Death		
Funeral Director		5. Social Security Number 216–58–5128	6. Sex		7. Age	(In yrs. la		day) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of Bir		Į.	oreign	place (State	
/ any	-	Usual Residence of Decedent  10a. State 10b. County				10c. City,	Town or										10d. Inside (	
Maryland 28a-f show any d at once.	<u> </u>	Maryland Howard	l 					Colu	mbia 10f. Zip C	nde				On Cit	tizen of What	Count	1 Yes	2 <u>X</u> No
ith the Maryland 23a or 28a-f sho notified at once	5	8931 Footed Ridge	<u> </u>							)45					U.S.A			
4D 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Modical Examiner must be notified at once To Bo Commission by Eumaral Director	Illeran	11. Marital Status 1 Never Married 2 Ma	arried	12. Was De Armed F 1 X Yes		Ever in U.	S.	If Ye	es, specify	Cuban,	Mexican,		cify Yes or No Rican, etc.)	)-	White,	etc.	an Indian, Bl	lack,
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15-0036 Teled within 72 hours afturally glene. d other than "natural", the Medical Examine.	Completed	Elementary/Secondary (0-12)		College (				0	st of work	rdina	tor				h Day o	f Ad	ventist	Church
e, MD 21215-0036  1 and 2 should be filed within 7  Health and Mental Bygiene, item 27 is marked other than 7  TO BO COMPAN	립	17. Father's Name (First, Middle, Richard A. Alden						50			Rutl	h C.	First, Middle, Carlson					
MD 21 d 2 should Ith and Me n 27 is ma aumatic er	2	19a. Informant's Name/Relations Brian Alden (Sor		pe, Print )			181	-					ural Route Nu , VA 221		City or Town,	State,	Zip Code)	
ore, Institute of Healt If item		20a. Method of Disposition  1 Burial 2 Cremation		Removal f	rom Sta	ate Ple			tion (Name er place) W				Date 7-2009		Location - C	•		roinia
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other ir		4 Donation 5 Other Sp. 21. Sign Jure of Funeral Service	Licens	е	N	U128		22. N	ame and A	ddress on Kno	of Facility	Witz oad	ke Funei Columbia	cal l	Homes.	Inc.		- Grines
Physician /Medical Examiner		23a. Part I, Enter the disease, or failure. List only on cause Immediate Cause (Fin Isease or condition resulting in death)	on ead	ications that th line. Hypertens Due to (or as	ive At	heroscl	erotic					ardiac or	respiratory ar	rest, sh	hock, or hear	t	Between (	ate Interval Onset and eath
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Box 6876C e death certificate the attending physed for use as the b	F FEMALE:   23c. If yes, outcome of pregnancy   23d.   2								Month		ay	Year						
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Division  To the Hospital or Attendanting 24 hours after death virtin 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying P	hysici	an: To the be On the basis	of exa	y knowled mination a	dge, dea and/or in	th occur	red at the tion, in my	time, da opinion,	te and pla death oc	ace, and curred a	due to the cau	use(s) e and p	and manner place, and du	as stat ue to th	ed. e cause(s)	
To wit	Me	29b. Signature and title of certific	ег	and marine	Jaied	b		_	29c		number				d. Date signe		-	ar)
		30. Name and address of person	) who c	completed ca	use of	death (Iten	n 23a)			O.C.N	vi.⊏.				ugust 11,	2003		
		Russell Alexander MD		Assistant	Medic	cal Exar	miner		Penn S	street,	Baltimo	ore, MI	21201					
Sta Registr		31. Date fill of Contr. Day, 201	09	Ocher	Registra	ar's Stanat	ure	Ma					0	CMF				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ust Day **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner yland Greneral 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min Director and Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 ☐ No th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 100 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 o Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rivate 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be be 0 Pages 1 and 2 should ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau SIS er onnie wa Baltimore, Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) ponsville netro 21. Signature / Funeral Service Licen 22. Name and Address of Faility marc salto M 23a. Part F the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or reart failure. List only one cause on a ch line. Immediate v use (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-tran Due to (or as Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has performe certificate Division or Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 PER/Outpatient 3 DOA 1 Inpatient P within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) To the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person v

31. Date filed (Month, Day,

MORGAN

DHMH 17 Rev 1/2001

2300

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

md, mtts

29c. License number

LIBERTY HEIGHTS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #21, per FH 9894 8/17/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician JOHN BERRY AUGUST 0619 AM 20001 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Pay. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Months Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Modical Examiner must be notified at Baltimore 1 XYes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Blvd. Apt 502 U5A Kaven Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Rural Route Number, City or Town, State, Zip Code) Kalto, Md Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition -1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MO 21. Signature of Funeral Service Licensee 965 York Rd., Rulto, Md 21212 Diratory afrest, Approximate Interval Between Onset and Death George C. Spears, per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASC unknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of) requires that the death certificate be executed burial-transit Exami and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform this certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After Medical Certification: Hospital or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examîner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0018230 AUGUST 14,2009 me 3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print), Somanton Horpital, MD 21234 SHASHIDHARAN KACATHIL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 1151PM Marie Brutus 09 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore HUSPITal ancialistour Vorthwest Birthplace (State or Foreign Country) Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Hours Min. Months 1 □ M 2 KF Days Hait Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Windsor Mill 1 ☐Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1910 Meadongate Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Specify: Specify: 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1,4or 5+) Hramark Elementary/Secondary (0-12) 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernadun Kesia Blanc Beauvais 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1910 Meadongate Court Window Mill, MD 21244 Htzgerald 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licenses 22. Name and Address of Facility aughn C 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 moviths? 1 ☐ Yes 2 ☑ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 PR/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Box 68760 P.0. Division of Vital Records.

requires that the death certificate be executed and burial-tra attending physician for use as the buria peen has

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Funeral

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Completed

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?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maxical Examiner must be notified at

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

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Certification: To

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signed by t page 2 should within 24 hours after death.

To the Funeral Director. After this certificate homeletely filled in by the funeral director, pagospital or Attending hours after death. To the Hospital

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of

29a. Certifier

'naib! 31. Date filed (Month, Day, AUG

ertifier

M.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number D0062650

Old low + Road Randallstown

401 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) 6. Sex Funeral Months Days Hours 1□ M 2 🖼 216-24-662 10-31-1922 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it is Modical Examinat must be retified at 1 Nes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 451 2840 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2 **1**No Baltimore, Maryland 21215-0036 1 ☐ Yes Specify: ò 3 ₩idowed 4 Divorced laci Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 21 is marked other than any injury or other traumatic manner. urse Heal Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be orman ပ Informant's Name/Relationship (Typy. Print) Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Numb Her 2840 rranddav 20c. Location - City or Town, State Ob. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State ouden 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto MU21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar the attending physician and P.O. Box 68760, Due to (or as a consequence of) Physician/Medical as the I IF FEMALE: After this certificate has been signed by the attendir funeral director, page 2 should be detached for use. 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2.7 Division of Vital e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐No completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per taltimare Date filed (Month, Day, Year) Registrar's Sig State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 7:45 P Richard Hamilton Bair August 12 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8160 Ethan Ave. Talbot Easton 8. Date of Birth (Month, Day, You Nov. 29, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1919 1 ☑ M 2 ☐ F 89 Director Maryland 212-12-6047 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County show ral", or items 23a or 28a-f show 1 Yes 2 □ No Directo Talbot Easton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 21601 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any lajury or other traumatic event, the Man 8160 Ethan Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tayes 2 □ No If Yes, Give Year or Dates: 1944–45 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

director of manufacturing, engineering & research Elementary/Secondary (0-12) College (1-4or 5+) aircraft 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reuben Hamilton Bair Lillian May Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6300 Herrington Lane Preston, MD 21655 Louise Mattingly/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 8/16/2009 Mt. Hope Cemetery Woodsboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service I atharine Woodsboro, MD 21798 404 S. Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final esophageal disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical

**Physician** Examiner

> physician and s the burial-trans ending p been signed by the should be detached director,

> > rector: by the f

illed in t

Hospital within 24 hours a
To the Funeral completely filled Be

Certification: To

Medical

29a. Certifier

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

5 Other (specify)

3 Ectopic pregnancy

23d Date of delivery Month Day

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. demens

an

32. Registrar's Signature

24a. Was an autopsy performed 1 □Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 | Yes / 2 | No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man r of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) and manner stated 29h. Signature and title of certifier

29c. License number 0002392

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

125ton MD 21655 Lednum 136 Melindo Bu 31. Date filed (Month, Day, Year) AUG 17 2009

State Registrar

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DIVISION OF VITAL RECORDS, P.O. DOX 00/00, 8	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and physician to the the funeral director nane 2 should be defacted for use as the birtial-fransit
DIVIS	To the Hospital or Atte	within 24 hours after death.  To the Funeral Director: A

			se Type or Pri	int in Black Ir Naryland / Dep					le.				
	•	For State Registrar			ertificate of l			Reg. No. 20	09 26093				
		Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month		3. Time of Death				
Physicia /Madio		Gary Allen E	Brooks Sr.				August	08 20	009 5:57 PM				
/Medic Examin		4a. Facility Name (If not institution SINAI HOSPITA	n, give street and numbe	MORE		Location of Death	CITY	4c. County of	Death				
Funeral Director		5. Social Security Number 212-58-6465	6. Sex 7. A	Age (In yrs. last birthda) 57 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 7-8-1	ay, Year)	9. Birthplace (State or Foreign Country)  Aryland				
P .		Usual Residence of Decedent		10c. City, Town or I					10d. Inside City Limits				
Marylar a-f show	ctor	MD 10a. State 10b. County		Baltimo					XXYes 2□No				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In mortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exaction interformatic at once.	Funeral Director	10e. Street and Number 1325 Carolir	ne St		10f. Zip Code 21213			10g. Citizen of Wh	nat Country?				
death	nera	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13	I. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No	14. Race	- American Indian, White, etc.				
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be filed ntal Hygi sd other event, I	Be	17. Father's Name (First, Middle, William Brool	Last)			18. Mother's Nan Mable P		, Maiden Surname	)				
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mit. F partm portar y injur		21. Signature of Funeral Service		Final J	22. Name and Addre	ess of Facility	ltimor	e,MD 21	216				
permi Depa Impo any in		V.			Charisse	Woods	Fun.Sv	.3307Mc	ondawmin Av.				
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/Medical Examiner		resulting in death)	Due to (or ARF	as a consequence of):									
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cate by													
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signed by	þ	Part II. Other significant condition AIDS, HEPA							ibute to the cause of death?  3 ☐ Probably 4 ☐ Unknown				
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or Atter after deal Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could	minad   Zoe. Flace UI	Injury - At home, farm, , etc. (Specify)	street, factory, office			(Street and Number own, State)	er or Rural Route Number,				
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the be al Examiner: On the bas and manne	is of examination and/o	eath occurred at the r investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	ne cause(s) and ma e, date and place, a	anner as stated. and due to the cause(s)				
To the within To the comp	Me	29b. Signature and five of certifi	MB135			se number		_	1 (Month, Day, Year)				
		30. Name and address of person	n who completed cause	of death (Item 23a) (Type SINAL HOS	PITAL, 24	OI WBE	ELVEDE	RE AV, BI	ALTIMORE, MD				
Sta Registi		31. Date filed (Month, Day, Year	2009 July	gistrar's Signature	arke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11 per FH C894 8/17/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 08:57 AM ARNOLD BERLIN 2009 aug 167 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL HOSPITAL OF BALTIMORE BALTIMORE CITY Berl 8. Date of Birth 07/15/1955 Birthplace (State or Foreign Country)

MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex 1 M M 2 □ F **Funeral** Min. Months Days Hours 54 212-50-7212 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extrainer must be redified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Arnold 21209 USA 1815 RAMBLING RIDGE LANE, #102 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No Maryland 21215-0036 Specify Specify: 3X Widowed 4 Divorced þ Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES MAINTENANCE SUPPLIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JEROME** BERLIN ELAINE SAMET ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JEROME BERLIN / FATHER B440 ASSOCIATED WAY, #104, OWINGS MILLS, MD 21117 Shert Baltimore, 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEMORIAL 08/14/2009 REISTERSTOWN, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Juneral Ser 8900 REISTERSTOWN ROAD PIKESVILLE, MD emi 23a. Part1. Enter the disease, or complications that austral did the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final POLYMICROBIAL 3 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SMALL BOWEL NECROSIS Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: N/A 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 □ Yes 2 □ No Ö 9 Unknown signed by t the detach ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CVA with Locked-in Syndrome Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? on Hemodialysis has 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No OSA Tongue HLD. Cancer 1 ☐ Yes 2 🗸 funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? II or Attending Patter death.
I Director: After I din by the funers 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

State Registrar

Medical

31. Date filed (Month, Day, Year)

Kaspharinesing

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ROOPNARINESINGH 82. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS

MBBS

SINAL MOSPITAL OF

29d. Date signed (Month, Day, Year)

08/13/2009

Year

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

To the Hospital on within 24 hours af To the Funeral D

			For State Registrar	State of M	1arylan	•	artment of rtificate o		nd Mental H	ygiene Reg. No.	200	9 26	5095
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~	Physicia /Medic		DONALD	CHARLES		BIEL		JR.	Augus				3 A M
3	Examin	er	4a. Facility Name (If not instituti	on, give street and number	MEDIC	AL CENTE		, or Location of	Death	4C.	County of De	eath	
~	Funeral Director		5. Social Security Number 219-56-7157	6. Sex 7. A		last birthday) Yrs.	If Under 1 Yes	ar If Under 24	4 Hrs. 8. Date of B Min. (Month, L	Day, Year)		Birthplace (Sta Country)	
	pu >		Usual Residence of Decedent			ty, Town or Lo	ection						e City Limits
	f show	or	10a. State 10b. Count	y		timor							res 2 □ No
	r 28a-	irect	10e. Street and Number				10f. Zip Cod			10g. Citi	zen of What	Country?	
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9500	be lied within 72 hours after death with the Maryland Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Evaninar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒Divorce	If Yes, Give	3? ₫ No		Was Decedent of If Yes, specify C 1 □Yes 2🖎	uban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	No-	Black, Wi	merican Indiar hite, etc. White	1,
0-617	thin 72 hou ne. I <b>wedical E</b>	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed)  College (1-4or	r 5+)	(Give life, l	DO NOT use ret	ne during most o ired)		16b. Ki	nd of Busine	ss/Industry	
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ore	ë = 5		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	n 3 ☐ Removal from Stat	e i	_	sition (Name of natory or other p		Date			or Town, State	
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00/00	physic the b	dical		d. HE	PATI	112	LINF	ECTIO!	N			10 Y	EARS
O. DOX	sidan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Feta at time of a	aldeath 3[	☐ Ectopic pregn. ☐ Other (specify			-	23d. Date of Month	delivery Day	Year
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DIVISION OF	Io the hospital or Attending Prhystolan: The lay within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Coul. 4 ☐ Homicide deter	d not be rmined 28e. Place of I building,	njury - At h etc. <i>(Sp</i> ec <i>i</i>	ome, farm, str	eet, factory, office	ce	28f. Location City or T	(Street an own, State	d Number or	Rural Route I	Vumber,
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Registrar

AUG 17 2009 Person B. Jake

DHMH 17 Rev 1/2001

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,	/Medio Examin		4a. Facility Name (If not institution, give stree			4b. City, Town, or L	ocation of Death		4c. County of Deat	
mari.			FRAnklin square				dale		Baltin	
	Funeral		5. Social Security Number 6. Sex 1 ☐ M	2 <b>V</b> ) F	yrs. last birthday Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	4/ear) 9. Birt	hplace (State or Foreign buntry)
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	yland now		10a. State 10b. County	10c	. City, Town or l	ocation				10d. Inside City Limits
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	or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	be filed within 72 hours after death with the Maryland Ital Hyglene. od other than "natural", or Items 23a or 28a-f show event, it a Madical Even in the rotal bear of the data	Funeral Director	120 FLEMING DRIVE	(- D	-110	21222		neity Von or No	USA 14. Race - Ame	rican Indian
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121	e filed within al Hygiene. I other than ' vent, the Me	õ	17. Father's Name (First, Middle, Last)			COOK	18. Mother's Name	/First Middle I		ESTAURANT
and	l be fi	Be	HENRY CHAMBLISS				SARAH	, , ,	valder) carramey	
Maryland 21215-0036	should be and Mental s marked o	ဥ	19a. Informant's Name/Relationship (Type. F	Print)	19b. Ma	ling Address (Street ar			r, City or Town, State, .	Zip Code)
Z	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic en		JUANITA JACKSON/DAUG		621	NEW PITTSE	BURG AVE.	BALTI	MORE, MD	21222
Baltimore,	ss 1 a of Hea		20a. Method of Disposition		Db. Place of Disp	oosition (Name of ematory or other place,	) [	Date	20c. Location - City or	Town, State
Ē	Page ment ant: If ury o		1  Burial 2 □ Cremation 3 □ Remo Donation 5 □ Other (Specify)			NISLAUS CE		19-2009		E, MARYLAND
alt	Departi Departi Imports any Inj once.		21. Signature of Funeral Service Licensee							NS F.H., INC.
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Е			23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one car	use on each line.				or respiratory arr	est,	Approximate Interval Between Onset and Death
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Aspirati	0n P	neumoni	ia			
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P.0.	he de / the a	ysic		☐ Pregnant at time ☐ Unknown	e or death - 8	i ☐ Other (specify)				
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Division of Vital Records,	quires in sign	sd by						1 □ Y	es 2 □ No 3 □ P	robably 4 Junknown
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Ä	The la	mo						autops perfor	med? death?	
ita	Physician: r this certificaral director, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat			
×	hysical this call dire	ည	1 Yes 2 No Hospi	1 d Inpatient			4 LI Nursing Ho	me 5 Resid	ence 6 ☐ Other (Spe	ecify)
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<u>&gt;</u>	or A after Direc	Certification:	4 ☐ Homicide determined	Be. Place of Injury - building, etc. (S	pecify)	street, factory, office		City or Tow		urai noute Number,
_	spital iours neral		29a. Certifier 1 Certifying Physicia	n: To the best of my	/ knowledge, de	ath occurred at the tim	e, date and place,	and due to the	cause(s) and manner a	as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examiner: one)	On the basis of exa and manner stated.	mination and/or	investigation, in my op	inion, death occur	red at the time, o	date and place, and du	e to the cause(s)
	To the within To the complete complete the c	M	29b. Signature and title of certifier			29c. License			29d. Date signed (Mon	
			11/AZ- MD			D62	373		8-13-	2009
			30. Name and address of person who comple	eted cause of death	(Item 23a) (Typ	e, Print)	11	T / 2	+ -	14- 10 /
			30. Name and address of person who complete the person who can be presented the person who can be presented the person who can be presented the person who can be	4000 FF	SHAKLLA	1 Square	HOSPI	al Ce	nler 13a	170 md 21237
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 19 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 13 2009 Victoria /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner m Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 6 Sex **Funeral** Year) 1 □ M 2 🗙 F 1101 219-80-1422 MARY/AND Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantities could be notified at any injury or other traumatic event, the Medical Evantities could be notified at any injury or other traumatic event. 1 Yes 2 □ No BALTIMORE Director MD. 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21216 3402 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SECURIT Elementary/Secondary (0-12) College (1-4or 5+) GUARD 10 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be SAMPSON ELAINE ပ္ or Rural Route Number, City or own, State, Zip Code) 21216 19b. Mailing Address (Street and Number 19a, Informant's Name/Relationship (Type, Print) BALTIMORE, MARIJAND
Date 20c. Location - City or Town State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State RMEI CEME. 19 2009 BALTIMORE, MARYIND 22. Name and Address of Facility DERRICK C. JONES FIH, P.A. CARMEI CEME! 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 4611 PARK HOTS. AVE., BALTIMORE, Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 W Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 XNo filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: A 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

within 2 To the the

State

29b. Signature and title of certifier

Registrar's Signature

30. Name and address of person who combeted cause of death (Item 23a) (Type, Print)

29c. License number

54

Baltimore

29d. Date signed (Month, Day, Year)

			_ State	State of Ma	ryland / Dep <i>Ce</i>	artment of F ertificate of			ene 2 () () 9	26098
			Registrar  1. Decedent's Name (First, Middle, Last)			Timoato or				3. Time of Death
	Physicia /Medic		Samuel Ches	rnut				2. Date of Death Month	Day Year 200	9 04:57 AM
	Examin		4a. Facility Name (If not institution, give st	,		1 1	r Location of Death	10	4c. County of Dear	h
			5. Social Security Number 6. Sex	501CO 7. Age	(In yrs. last birthday	170	If Under 24 Hrs.	8. Date of Birth	9. Bir	hplace (State or Foreign
	Funeral Director		239-56-2789 😾	M 2□F	70 Yrs.	Months Days	Hours Min.	Jan. 25		N.Carolina
	and w		Usual Residence of Decedent  10a. State		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla -f sho	ţo	Maryland N/A		Balti	lmore				1 <b>∑</b> Yes 2 ☐ No
	n the l	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a c		3612 Manchester	Avenue			215		USA	
21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Medical Examinating The hollified at	by Funeral	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of I If Yes, specify Cub 1 □Yes 2☐No	Hispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Ye's or No- o Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
2-0	72 hou	Completed	15. Decedent's Educa (Specify only highest grade	ation	16a. Dece	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of work	kina 10	6b. Kind of Business	
121	vithin in the ine.	mple	Elementary/Secondary (0-12)	College (1-4or 5+	.)					ate Folding
9	filed v Hygie other t		10th grade  17. Father's Name (First, Middle, Last)		Macni	ine Adju		pervison ne (First, Middle, Ma		
<u>lan</u>	2 should be and Mental Is marked c	To Be	Samuel Chestnut				Kati	e Bess		
Maryland	5 TO 1		19a. Informant's Name/Relationship (Type Sherry Smith-Che		Wife 36	ing Address <i>(Str</i> eet 512 Manc	and Number or Ru hester	<sub>iral Route Number,</sub> Avenue I	City or Town, State, Baltimor	<sup>Zip Code)</sup> 21215 e,Maryland
Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Druid R	osition (Name of matory or other pla idge Cel	netery	5/09 Wo		Maryland
Balt	permit. Pages Department of Important: If ii any Injury or once.		21. Signature of Funeral Service Licensed	is	2	22. Name and Address 5240 Rei	ess of Facility Ch stersto	atman-Ha wn Rd Ba	arris Fu	neral Home ,MD 21215
			28a. Party. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each line	the death. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		nordal					days
	Examiner			Due to (or as a	consequence of):					0
	77 +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	1				
128	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Bull		lev				
68760,	be ex	a E	d .	Due to (or as a	consequence of):					
687	ificate g phys	edical	d.							
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live birth 2 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnan ☐ Other (specify)	су		23d. Date of de Month	elivery Day Year
rds, P.	quires that in signed b	Š	Part II. Other significant conditions cont An OXIC Brawn Fi	ributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.		acco use contribute t s 2 □ No 3 □ F	o the cause of death?
Reco	he law re te has bee age 2 sho	Completed	Braseral Puli	nonary		i		24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
ta	ian:   ertifica ctor, p	Be C	25. Was case referred to medical examiner?	y mse	250		26. Place of Dea	1 □Yes 2 ath <i>(Ch</i> eck only one		2010
Ž	hysic this ce al dire	ျှ	1 ☐ Yes 2 X No		nt 2 ER/Outpatie	ent 3 L DOA	<del></del>	lome 5 Resider		ecity) Hospice
ou c	ding F h. After funera	ijon:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	y 28b. Time ( Year) Injury	Wo	ıryat rk? ]Yes 2. □No	28d. Describe how	v injury occurred	V
Division of Vital Records,	I or Atten after deatl Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)			28f. Location (Str. City or Town,	eet and Number or F State)	lural Route Number,
_	Hospita 24 hours Funeral stely filled	Medical C	29a. Certifier (Check only one)		examination and/or					
	Fo the within Fo the comple	Me	29b. Signature and title of certifier	( )		29c. Licen	se number	29	d. Date signed (Mor	th, Day, Year)
			Matalu	400 /2	A	D	68286	0	8/8/	2009
	\		30. Name and address of person who cor NATALLE. WES	t. un	eath (Item 23a) (Type	over son to	mblu	a, Balt	more, M	D 21204
	Sta Registr		31. Date filed (Month, Day, Yeer) AUG 17 2009	32. Registra	r's Signature	las				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per DVR G894 8/11/09 JH

			For State Registrar		State of Ma	aryland / I		rtment of F tificate of		nd Me		giene Rog. No	L. U U	9	2509	J
	Dhariai		1. Decedent's Name	e (First, Middle, La	st)					2	Date of Dea	ath Da	v Yea	ar.	3. Time of Death	
	Physici /Medic		James	D. Crouch	1					A	ugust		2009		6:44 AM M	1
)	Examin		4a. Facility Name (I	f not institution, giv	re street and number)			4b. City, Town, o	r Location of	Death			4c. County of Death			
				nyon Aver				Severn					Anne A			
	Funeral		5. Social Security N	ĺ.	Sex 7.Age 1527M 2□F	e (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birt (Month, Day	v. Year)	9. 1	3irthpla Country	ce (State or Foreig	n
	Director		174-40-0	1111	K III 201		Yrs.			J	an 13,	19	49 No	rth	Carolina	l
	and and		Usual Residence of 10a. State	10b. County		10c. City, Tow	vn or Loc	ation						100	d. Inside City Limits	3
	f eho	ŏ	MD	Anne Ar	unde1	Seve	rna	Park						+	1 □ Yes 2√2 No	)
	28a-	Director	10e. Street and Nu					10f. Zip Code				10g. Cit	tizen of What	Countr	v?	
	n 72 hours after death with the Maryland "naturel", or freme 23e or 28e-f ehow school Examinat niest be notified at	<u></u>	612 Bany	yon Avenu	e				L46			_	USA		•	
	me 2	Funeral	11. Marital Status		12. Was Decedent B	Ever in U.S.	13. W	las Decedent of h Yes, specify Cub	lispanic Origi	in? (Specif	y Yes or No		14. Race - A			
٥	after or its		1 Never Marr	ied 2∑ Married	Armed Forces?	lo	j			Puerto Rio	can, etc.)		Black, W			
3	rel', o	by	3 ☐ Widowed	4 Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	66-70	1	□Yes 2]XINo	Specify:				Specify: V	vnit	.e	
2-003p	72 ho	etec	(Spec	15. Decedent's E	ducation ade completed)	16a		ent's Usual Occup		of working		16b. K	(ind of Busine	ss/Indu	istry unk	
7	c * 4	du	Elementary/Seco			College (1-4or 5+)			OO NOT use retired)							
Z	ygier yer th	Completed	12		4 1			manager								
and	d off	Be		17. Father's Name (First, Middle, Last)  Richard Lee Crouch						,		e, Maiden Sumame)				
<u>X</u>	Men Men Marks Marks	မှ									Jean :					
<u>a</u>	2 sh and r			ame/Relationship (				Address (Street							_	
ໝົ	l and tealth im 27			Sherman/s	pouse			Banyon A	venue	Seve			MD 2 ocation - City	1146		
E	Pages in the hand in the first or of in the first o				Removal from State	cemete	ary, crem	atory or other pla	cө)   	Dat	9	20G. L	ocation - City	OFTOW	n, State	
Saltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other treumatic event, Item 200ce.	1			Wade, Dire	ector	Sta	Name and Addre	ss of Facility Omy Bo	ard 6	555 W.	Ba1	Ltimore	e St	reet	
			23a. Parti.	he is as	plications that caused	the death. Do		ltimore,		1201	accirator, a	roet			Approximate	
			shock, or heart failure. List only one cause on each line.													
1	Physician /Medical		disease or condition resulting in death)						212	L				5	mon	h
	Examiner	ē	, ,	Due to (or as a consequence of):												
			Sequentially list co	nditions,	b. Fame to do a new	Due to (or as a consequence of):										
	ted nslt	Examiner	Sequentially list confidence in any, reading to include cause. Enter Under Cause (Disease or	erlying												
•	and al-trai	хаг	that initiated events resulting in death)	5	C						+					
09/99	licate be executed physician and s the burial-transit															
ά		edical			_ d											
_	siclen: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use a	/W	IF FEMALE: 23b. Was deceden	t oregonant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy							23d. Date of	deliven	v	
X D D	death	Physician/M	in the past 12		☐ S☐ Ectopic pregnancy			Month Day Year								
j.	the o	skc	1 □ Yes 2 ( 9 □ Unknown		9□ Unknown											
T	requires that the een signed by th hould be detache	by Pi	Part II. Other signif	ficant conditions	contributing to death be	ut not resulting	in the un	derlying cause gr	ven in Part I.		23e. Did to	obacco	use contribut	e to the	cause of death?	
ecoras,	uire n sign										101	Yes 2	100 3 E	] Probal	bly 4 □Unknow	n
Ŝ	law rec as bee	Completed									24a. Was	an /	24h Were	autons	sy findings availabl	е
E E	he la e has	Ĕ									autor	osy ormed2	prior	to com	pletion of cause of	
VII all H	ifficat	ပိ	25. Was case refer	red to medical					Of Place	of Dooth /	1 ☐ Yes Check only o	2 NO	1 1 1	/es 2	.U No	
>	s cert	0 8	examiner? 1 ☐ Yes 2 S	4	Hospital: 1  Inpatie	nt 2 ER/O	utnationt	3□ DOA Ot			1		6 Other (5	Specific)		
0	or Attending Physicien: ifter death. Director: After this certifici	-	27. Manner of Dat	/	28a. Date of Injui (Month, Day		Time of	28c. Inju			d. Describe I			рөспу)		
0	th.: Afte	ig Ig	1 Natural 2 Accident	5 Pending investigation		/ Year)	Injury		rk? ∣Yes 2.∐N	0						
IVISION	Atter r dea octor	flee	3 ☐ Suicide	6 Could not b	286. Place of inju	ury - At home, f	arm, stre	et, factory, office		28				Rural	Route Number,	
5	afte afte	Certification:	4 ☐ Homicide building, etc. (Specify)  City or Town							wn, State	θ)					
	To the Hospital or Attending Physicien: The i within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	Certifying Pl	nysician: To the best of	examination at	e, death	occurred at the ti estigation, in my	me, date and opinion, death	place, and	d due to the at the time,	cause(s date an	and manne d place, and	r as sta due to t	ted. the cause(s)	
	thin (	Mec	29b. Signature and	title of certifier	and manner sta			29c. Licen	se number			29d. Da	ate signed (M	onth D	av. Year)	
	8 ≒₹∃			00	1	Λ , Ω			29c. License number 29d. [			1,0	prot		,2009	1
			20 14	V W	asmolar d	- (V · 1)	(T. : -		→ (-J	,	17 Just 11, 20		1 -00			
			Yudhi	shtra Mar	completed cause of deckan 305 H	eath (Item 23a) <b>lospital</b>			nn Bur	nie M	id 210	61				
	Sta	te	31. Date filed (Mon	th. Day, Yearly		ar's Signature										
	Registr			AUG 172	009 /	a p.	190	ulas								

		•	For State Registrar	State of	Maryland		rtment of H tificate of L		Mental Hyg	iene g. No.	09	26100
ı	Q.		1. Decedent's Name (First, Middle,	Last)	+ 110				2. Date of Deat Month	Day	Year	3. Time of Death
	Physicia /Medic	al .	Virginia		tella				August	_	2009	6.39AM
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or		th		y of Death	
L			Ellicott City  5. Social Security Number		Rehab '. Age (In yrs. la:		Ellico	tt City If Under 24 Hr	s. 8. Date of Birth	Но	ward	place (State or Foreign
	Funeral Director		215-14-8954	1□M 2∏F	. Age (111 )/13. 1a.	Yrs.	Months Days	Hours Mir		Year) 1921	Cour	yland
			Usual Residence of Decedent									
	uylan show	_	10a. State 10b. County		10c. City,	Town or Lo	cation				1	1 ☐ Yes 2 ☐ No
	8a-f s	cto	MD Howar	d		Ellico	ott City			0g. Citizen of	NATIONAL CONTRACTOR	Λ
	with the		10e. Street and Number	D 1			10f. Zip Code	1042	"	USA		itt <b>y</b> r
	eath is 23	era	11108 Dorsch F		dent Ever in U.S	. 13. V			Specify Yes or No-	14. Ra	ice - Am erio	
·0	ffer d r item	Funeral Director	1 Never Married 2 Marrie	Armed For	ces? 2 🕅 No				Specify Yes or No- rto Rican, etc.)		ack, White,	
ğ	ours a	by	3 🖫 Widowed 4 □ Divorced	If Yes, Give Year or Da	tes:		I∐Yes 21X No	Specify:		Speci	whi	.te
2	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show he Mailca Examiner musi be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	lent's Usual Occupa kind of work done of OO NOT use retired	luring most of w		16b. Kind of E	Business/In	dustry
2	wifhin ane. than	шр	Elementary/Secondary (0-12)	College (1-	4or 5+)	_	lministra:		rotors	bottli	ina aa	any any
0 0	Hygid Hygid Sther		17. Father's Name (First, Middle, L.			au	шиньста		me (First, Middle, I			ompany
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. I am demonial Hygiene is marked other than "natural", or lieums 23a or 28a-f show aumatic event, the Modical Examiner must be notified at	To Be	Thomas W. Sim	pson				Mari	le M. Borg	meier		
ary	and N		19a. Informant's Name/Relationshi						Rural Route Number			
Σ.	and 2 ealth n 27 in		Patricia Bent/	daughter				Farm Ro	ad Ellico			
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☑ Donation 5 ☐ Other (Spe		COL	ace of Dispo metery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location	- City or 10	own, State
Balt	permit. Departn Imports any inju		21. Signature Funeral Serice Li Ronal Li S	MINE	irector	- St	1+imoro	my Boar	d 655 W.		ore S	treet
			23a. Pan1. Enter the disease, or o shock, or heart failure. List o	omplications that can nly one cause on ea	used the death. ich line.	Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory arm	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Alken	sclerol	ic C	ardiovas	Calar	Disea	ioe		Onset and Death
	/Medical Examiner		resulting in death)	500 10 (	or as a consequi	ence of):	mentis					
L		Examiner	Sequentially list conditions, if any, leading to immediate	b. Advanced IZemen LIG  Due to (or as a consequence of):								
	uf <b>e</b> d d ansit		cause. Enter Underlying Cause (Disease or injury that initiated events	6.								
oʻ	te be execufed ysician and ie buriaf-transit		resulting in death) Last	Due to (	or as a conseque	ence of):				-		
8760,	ate be hysici fhe bu	lical		d								
89 x	that the death certificate be executed of by the attending physician and detached for use as the buriat-transit	Physician/Med	IF FEMALE:	23c If yes outo	come of pregnan	icv				234 5	ate of deliv	en.
Вох	affend I for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	rth 2 Fetal	death 3□	Ectopic pregnancy Other (specify)				Month	Day Year
o.	the d	lysh	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno								
ď.	res thaf igned b	by PI	Part II. Other significant condition	s contributing to de	ath but not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to 1	the cause of death?
ğ	w require been sig should b								1 🗆 Yı	es 2 No	3 Pro	bably 4 Onknown
Vital Records,	2 2	Completed							24a. Was a autops perfort	sy /	prior to co death? 1 \( \subseteq \text{Yes}	opsy findings available ompletion of cause of
ita		Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only or			
of <	Phyaician: this certific ral director,	To	1 Yes 2 No		npatient 2 E			Nursing	Home 5 ☐ Reside			ify)
ū		on:	27. Manner of Death  1 Natural 5 Pending		h, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	ow injury occi	urred	
Sio	Attending r death. ector: After by the fune	Icat	2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be determined by the state of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or							n <i>ber or R</i> ur	al Route Number.	
Division	after after Direct In by	Certification:	4 Homicide determin	ned buildir	ng, etc. (Specify)	)	eer, ractory, onice		City or Tow			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: complefely filled in by the	cai	(Check only 2 Medical E	xaminer: On the ba	sis of examinati	on and/or in	vestigation, in my o	pinion, death oc	ce, and due to the c curred at the time, d	ate and place	e, and due t	to the cause(s)
)	To the within 2. To the complet	Me	29b. Signature and title of certifier	& Claur			29c. Licens	30641	2	19d. Date sign	ned (Month,	Day, Year) 9
			30. Name and address of person	no completed caus	e of death (Item	23a) (Tyoe,	Print) VUMCCK	Road	Balhm	you N	10 7	1/22/
42	Sta Registi	ite rar	29b. Signature and title of certifier  30. Name and address of person of the fill of the f	9 General	egistrar's Signat	park						

			1 - For State Registrar	State of	Marylan	•	artment of H rtificate of L			ene 2 0 0	9 26 10 1	
Ī	Physici	an	Decedent's Name (First, Middle)	e, Last)					2. Date of Death Month		3. Time of Death	
	/Medio	cal	Fr: tz Cox  4a. Facility Name (If not institution	n give street and num	nher)	4b. City, Town, or Location of De			August	12 200		
	Examir	ier	University of t		iber)		Baltimore MD			4c. County of Death  Baltimure ary		
	Funeral Director		5. Social Security Number 222–36–8011	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age <i>(In yrs.)</i> 56		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 23	9. B 1952 De	irthplace (State or Foreign Country) Laware	
	w w		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Loc						
	Maryli Pf sho	ţō	DE Kent	Ė	1001.011	Camder		1 □Yes 2 No				
	or 28s	Director	10e. Street and Number	_			10f. Zip Code		10	g. Citizen of What (		
	eath w	Funeral	918 Tobacco Roa	12. Was Dece	dont Ever in III	C 42 V		934	andfu Va a or No	United S		
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. sd other than "natural", or Items 23a or 28a-f show event, if a Modical Evar incr must be notified at	þ	11. Marital Status 1 □ Never Married 2□ Marri 3 □ Widowed 4 █ Divorced	Armed For	ces? 2  No e	l II	Was Decedent of Hi fYes, specify Cuba I□Yes 2 ANo	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	nerican Indian, iite, etc. White	
2-0	"natur	letec	15. Decedent's Education 16 (Specify only highest grade completed)				lent's Usual Occupa kind of work done of OO NOT use retired	ation Juring most of work	6b. Kind of Business/Industry			
212	l withir jene. r than	Completed	Elementary/Secondary (U-12)   College (1-40r 5±)				Self Emplo		Construc	tion		
nd	< C m o	To Be C	17. Father's Name (First, Middle,	,					e (First, Middle, M	· · · · · · · · · · · · · · · · · · ·		
Maryland	should be f and Mental s marked o umatic eve		Janette Amelia Rosengren									
	1 and 2 sho Health and em 27 is ma ther trauma		19a. Informant's Name/Relationsh Kevin Cox, Brot			1	•		•	ware 1993		
Baltimore,	S = = 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		c	emetery, crem	sition (Name of natory or other place 11 Memor:	e) !		9 Dover	or Town, State , Delaware	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Fune of Service	Licensee T	. Harma		Name and Addres			neral Hom 19901	e, Inc.	
	Physician	10 1	23a. Part 1. Enter the disease, or shock, or heart fallure. List Immediate Cause (Final disease or condition	only one cause on ea	used the death ch line.		er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (d	or as a consequ	uence of):					Iweek	
	, p +	al Examiner	Sequentially list conditions, if any, leading to immediate	D	r as a consequ				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	xecute and I-transi		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ionae of				2 days				
58760,	ficate be executed physician and s the burial-transit		,	d Due to (t	r as a consequ	ience on).						
89	rtificat ng phy	Medical	IF FEMALE:	u								
$\supset$	the death certificate be executed by the attending physician and ached for use as the burial-transit	d by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1							lelivery Day Year		
rds, P.	e law requires that the de has been signed by the e 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								to the cause of death?	
I Kecords,	The law re ate has bee page 2 shor	Completed							24a. Was an autopsy perform 1 □ Yes 2	prior to ed? death	autopsy findings available o completion of cause of	
Vital	ician: sertific	Be C	25. Was case referred to medical examiner?	11 0 1					h (Check only one		2010	
0	Phys r this c ral din	- To	1 Yes 27 No Hospital: 1 Hapatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								pecify)	
0	nding ath. r: Afte	ation	27. Manner of Death  28a. Date of Injury  28b. Time of Injury at Work?  2 Accident investigation  28d. Describe how injury occurred Work?  1 Yes 2 No									
DIVISION	tal or Atters after de al Directo ed in by the	Certification:	3   Suicide 4   Homicide   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   28f. Location (Street and Number or Rura City or Town, State)							Rural Route Number,		
)	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier 1 Sertifyin (Check only one)	g Physician: To the Examiner: On the ba and mann	sis of examinat	wledge, death tion and/or inv	occurred at the tin restigation, in my op	ne, date and place, pinion, death occur	, and due to the ca red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)	
	Verith Com.	Σ	29b. Signature and title of certifier	, 11-	MO		29c. License		_	d. Date signed (Mo.		
•		}	30. Name and address of person v	1 Ha		23a) (Tuno E		91497	/	August 12	212007	
			Jinny Ha		renc s			ive , MD	21202			
I	Sta Registra		31. Date filed (Month, Day, Year) <b>AUG 1 7 2009</b>		gistrar's Signat		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06325 State of Maryland / Department of Health and Mental Hygiene Reginald Darnell Dredden 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Reginald Darnell Dredden 2. Date of Death Physician/ 2130 hrs August 12, 2009 **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 302 E. Lanvale Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Davs Country) Maves ke 8 1978 Director 1 M 2 212-92-625 Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10b. County Yes 2 No NIA Baltimore 28a-f show navyland Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, of tentral Trians 27 sa nated other than "natural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once, Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number Lanvale 212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status 1 Never Married 2 Married Yes Bluck Specify: If Yes, Give Year Yes 2 No specify. Widowed Divorced Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 NONE Jone 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reginald Be Dredden Jannie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore Ave 6 vount Mareco Rabecca 3101 Mathor 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 3 Removal from State NC 120109 Department of Rockford Cemetery Other Specify Donation 5 22. Name and Address of Facility

(ALVIN L. WILL IMMS) 21. Signature of Funeral Service Licenses A. U 270 Fredhitter , MD 21229 timove 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute meningoencephalitis and vasculitis Approximate Interval **Physician** Between Onset and Death /Medical Concentric Left Ventricular Hypertrophy Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 23a,per ME g899 1/28/10 TT #1,23a,27,permE, g897 11/13/09 TT The law requires that the death certificate be execu Physician/Medical X UNPENDED attending physician a Box 68760. 23d. Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö à Yes 2 No 3 Probably 4 V Unknown σ. Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has 2 s performed? ✓ Yes 2 1 🗸 Yes No this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 1 V Yes 2 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending To the Funeral Director: Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined Δ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. ame and a dress of person who complete

Theodore M. King, Jr., MD.

cause of death (Item 2 a)

Assistant Medical Examiner

32, Registrar's Signature

29c. License number

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

August 13, 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mantingust 13. 2009 Physician/ Kenneth Bartlett Didier 9:28 P Medical 4c. County of Death

Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Gilchrist Care Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Hours September 20, 462-44-4362 81 Mary Land 1927 Director Usual Residence of Decedent 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location Grasonville Director Oueen Anne's notified Maryland 28a-f 1 Yes 2 No 10f. Zip Code 21638 10e Street and Number 10g. Citizen of What Country? must be 1027 Long Point Road 23a Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 9 ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 → Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12. College (1-4 or 5+) Self Employed Surveying Instrument Repairer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of Fred B. Didier Theo Aldrich traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6107 Carter Avenue Baltimore MD 21214 Department of Health ar Important: If item 27 is any injury or other trauonce. Stephanie McDermott/Daughter timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
HilltopService Corp. 1 🗆 Burial 2 😾 Cremation 3 🗆 Removal from State 8/19/09 TowsonMaryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LEFT HIP DISLOCATION

Due to (or as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner STEOFOROSI if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi CHRONIC OBSTRUCTUS and resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) #OSPICE 2 🗌 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred LEGS GANE OUT SECONALY TO WEAKNESS AND PT FELL TO FLOOR 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 No AUGUST 13,2009 AROUND OSCOPM Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 914 STEVENSON LANE TOWSON, MA DAUGHTERS HUME Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 264395 AUGUST 14,2009 person who completed cause of death (Item 23a) (Type, Print) 6701 NORTH CHARLES ST, SUITE 4105 TOWSON, MB 21204 DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month () **Physician** Dickerson, Jr. Hubert Benjamin /Medical 4c. County of Death Kacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Min. Months Days Hours 1**X** M 2 ☐ F 214-24-4633 81 Director January 23,1928 New York Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State or 28a-1 show 1 TyYes 2 □ No n/a Baltimore City Be Completed by Funeral Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3417 Roselawn Avenue 21214 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ♥ Yes 2 □ No If Yes, Give Year or Dates: WW I 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married ō 1 ☐ Yes 2√ No Specify: Speciathite WW II 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 yr's Steel worker Steel Industry marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) - pe Hubert Dickerson, Sr. Mildred Dzierzyk 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21286 Frank Lidinsky - Attorney 8600 LaSalle Rd. Suite 320 Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: if it eny injury or o 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest V.A. 8/17/09 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service: Licenses Baltimore, Maryland 21214 5305 Harford Rd. Leonard J. Ruck, Inc. Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner weeh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit to the Hospitel or Attending Physicien: The law requires that the death certificate be executed CHATTERCATION APPROVED BY MENT resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No 1 Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 Pr/Outpatient 3 DOA 28a. Date of Injury After thi funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 8:30 AM 1 Natural 5 Pending death. 1 Yes 2 No investigation 08 2 Accident Stair within 24 hours after deal To the Funerel Director. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Home 7 Koselaun Aue 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Name and address of person who co mpleted cause of death (Item 23a) (Type, Print) Good samar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

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Registra

7 1

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** August 11, 7:50 AM W. Dawson George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 7205 Waldman Avenue Edgemere If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 88 West Virginia 235-18-3126 Jan. 8,1921 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notitled at 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 □Yes 2X No Director Edgemere Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 7205 Waldman Avenue 21219 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Ye ar or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ρ Specify. 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Steelworker 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara V. Youngblood Horatio Rhine Dawson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar Edgemere, Maryland 21219 Health a 2622 Edgemere Ave. (Son) Keith Dawson Item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD Holly Hill Mem. Gdns. 8/14/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk Inc 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1sease **Physician** Imonas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se ventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Yes icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2**√** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 -Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 Hugust 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Medical Ctr. 21224 32. Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, AUG 17

Surte

32. Registrar's Signature

Imore, Md 2120 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Charles

Year)

		1 - State Certificate of Dea	ath		g. No.	
Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	
/Medic		Ida E. Fry		August	12, 2009 4c. County of De	12:30 A
Examin	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loca	ation of Death	:		_
		9107 Contee Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs.	8. Date of Birth (Month, Day, Y	Prince 9. Bi	irthplace (State or Fore. Sountry)
Funeral Director		579-66-4354 1 M 2 XF 58 Yrs. Months Days Ho	ours Min.	Oct.10.		ountry) <b>ashington,</b>
		Usual Residence of Decedent		0001101		
how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limit
Ba-f	Director	Maryland Prince Georges Laurel		1.0		
or 2	Dire	10e. Street and Number 10f. Zip Code			g. Citizen of What C	Jountry?
18 236	eral	9107 Contee Road 20708  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani	nic Origin? (Spe		SA 14. Race - Arr	nerican Indian,
tal Hygiene manner in a manner tal Hygiene then "nature", or tem s 23a or 28a-f ehow event. I'm Medical Examine mant to notified at	by Funeral	Armed Forcety! If Yes, specify Cuban, Me	lexican, Puerto l pecify:	Rican, etc.)	Black, Wh	White
nature		15. Decedent's Education 16a. Decedent's Usual Occupation	) 	16	6b. Kind of Busines	s/Industry
then "n	Completed	(Specify only highest grade completed)  [Give kind of work done during life. DO NOT use retired]  [Elementary/Secondary (0-12)   College (1-4or 5+)	g most or workii		Dwn Home	
Hygiene.	Com	12 Homemaker				
d other	Be (	17. Father's Name (First, Middle, Last)	Mother's Name	(First, Middle, Ma	aiden Surname)	
and Mental is marked c	ျှ	Har ora Willedier		Henry		
is m	1	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Nature of Processes</i> )  19c. Mailing Address ( <i>Street and Nature of Processes</i> )				
it of Health and Mer If item 27 is marke or other treumetic		Wayne Wilkinson/Son 9916 Rosewood F  20a. Method of Disposition 20b. Place of Disposition (Name of			Oc. Location - City of	
or of		1 Deurial 2 Cremation 3 Removal from State Comfort Cem				
rtmer rtent njury		. 4 □ Donation 5 □ Other (Specify)  21. Sign for e of FuneranService Licensee  22. Name and Address of	Aug.		Alexandi	ria, va. eral Home
Department of Health a Importent: If item 27 is eny injury or other tre garce.		Laux Corner CC050 171 W. Map				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.			st,	
		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Cancer of Colon with Metast	uch as cardiac c		st,	Interval Between
Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	uch as cardiac c		st,	Interval Between Onset and Death
Medical	ľ	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cancer of Colon with Metast Due to (or as a consequence of):	uch as cardiac c		st,	Interval Between Onset and Death
hysician /Medical xaminer	nlner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cancer of Colon with Metast Due to (or as a consequence of):  b. Due to (or as a consequence of):  b. Due to (or as a consequence of):	uch as cardiac c		st,	Interval Between Onset and Death
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Medical xaminer	dlcal	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  List only one cause on each line.  Cancer of Colon with Metast  Due to (or as a consequence of):  b.  Due to (or as a consequence of).	uch as cardiac c		st,	Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200<sup>9</sup> **Physician** 5:45 рм Carmella Grossi August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris If Under 1 Year 8. Date of Birth (Month, Day, Aug. 29 9. Birthplace (State or Foreign If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Hours Days 1 □ M 2**X** □ F Pennsylvania 87 1921 097-14-1502 Aug. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene. Important; if item 22 or 28a4 show important; if item 27 is marked other than 'natural', or items 23a or 28a4 show important; if item 27 is marked other than "higher and price ovent, If a Medical Examinar must be notified at once. 1 ☐ Yes 2X No Yonkers Westchester Directo NY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 10704 USA 17 Murray Ave Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: þ White 3 X Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within intent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Colisto Antonio Duronio ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13019 Heil Manor Dr. Reisterstown, Md. 21136 19a. Informant's Name/Relationship (Type. Print) Mr. Richard Grossi/ Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-17-09 Hartsdale, NY Ferncliff Cemetery 4 □ Donation 5 NOther (Specific ntombment <sup>22. Name and Address of Eacility</sup> Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Juneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovancular Disease **Physician** Atheroscieronc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown ρ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page 2 1 □Yes 2 □No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Medical Certification: To this. 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) NURSE PRACTITIONNESS ated. (Check only

of Vital Records, CARMELLA Division ROSSI,

o

Baltimore, Maryland 21215-0036

AUGUST

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

JENNIFER HAUF,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

2300 DULANEY VALLEY ROAD

K157629

29d. Date signed (Month, Day, Year)

8/14/2009

21093

TIMONIUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1 Decedent's Name Day 16,05 onth **Physician** 3P G451 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ashland If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 M 2 F Yrs min 220-14-6659 Usual Residence of Decedent November 24,1918 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show ury or other traumatic event, Ite M. dical Examinat must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No Completed by Funeral Director BAITIMORE 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 2120 5,4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) - Holibird Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Worken None 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address Street and Number of Rural Route Number, City or Town, State, Zip Code) HEARY ဂ္ nomA 5 19a, Imprmant's Name/Relationshij (Type, Print) MII) 21202 20b. Place of Disposition (Name of gemetery, crematory or other place) 1000CC 20c. Location - City or Town, State Date Method of Disposition 18,209 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of important: If any injury or once. WingsMills tor 22. Name and Address of Eacility Eunena 21. Signature of Funegal Service Licensee BAID MI) 112911. AROlino 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) GLIVUSI Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examine the attending physicien and hed for use as the burial-transIt The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy 2 🗌 No 1 Yes 1 Yes 2 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 2 🗌 No 1 🗌 Yes 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) derson wit completed cause -011

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 12:39 A M Goodpasture Kim August Denice 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford Bel Air Upper Chesapeake Medical Center 8. Date of Birth (Month, Day, Year) 11/19/1965 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min 1 □ M 2 1 F Germany 213 94 6966 43 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 1 Yes 2 □ No Aberdeen Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 321 Dennison Way 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 □Yes 2 🛂 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At home Handicapped 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Hopkins William Goodpasture 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 321 Dennison Way, Aberdeen, MD 21001 William Goodpasture (father) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/17/2009 Aberdeen, MD 5 ☐ Other (Specify) Harford Mem. Grdns. 4 ☐ Donation 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Park I. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral Pulmonary week disease or condition resulting in death) Due to (or as a consequence of): 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 MNo 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 100 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

10a State

Directo

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertines installed and once.

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2009

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Baltimore, Maryland

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Division of Vital Records,

the burial-tran use as t for detached ģ cate has been signed page 2 should be det certificate has director,

his

Physician/Medical

the Hospital or Attending Physician: funeral After t within 24 hours after usum.

To the Funeral Director: Aft

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Completed by Be Certification: To

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier (Check only one)

31. Date filed (Mo

2 Accident

4 ☐ Homicide

State Registrar

Medical

5 Pending

investigation 6 Could not be determined

29b. Signature and title of certifier

and manner stated.

28a. Date of Injury (Month, Day, Year)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

H0067817

28c. Injury at Work?

1 ☐Yes 2 ☐ No

13,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500

pper chisapeake center, he Air, MD 32 Registrar's Signatu

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

DHMH 17 Rev 1/2001

Mariam Bakir,

AUG

31. Date filed (Month, Day, Year)

CRNP

AUGUST

Timonium, MD 21093

2300 Dulaney Valley Rd.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 620 B **Physician** 2009 290 /Medical 4a. Facility Name (If not institution, give street and number, County of Death 4b. City, Town or Location of Death Examiner 4more chdells 050 If Under 1 Year | If Under 24 Hrs. Bi thplace (State or Foreign Couptry) 6. Sex Age (In yra! last birthday) **Funeral** Months Days Hours 1 M 2 3 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City flown or Location 10b County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at 1 □Yes 2 10 No Funeral Director 10g. Citizen of What Country 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retiged) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary (0-12) College (1-4or 5+) FICE 18. Mother's Name (First, Middle, Maiden Surnar 17. Father's Hame (First, Middle, Last) Be IALR lahous ဂ္ and Number or Rural Route Number, City or Town, 19a Informant's Name Relationship (Type. Print) Department of Health ar Important: if item 27 is any Injury or other trau once. 1U/AR 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) eral ervice Licensee 21. Signatur of T Approximate Interval Batween Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Year Month Day Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 25 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¶ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Medical Certification: To 27. Marther of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1da Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

State Registrar

31. Date filed (Month, Day, Year) AUG 1

29b. Signature and tipe of eertifu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #205164ce BeMaFMa6895 DeSander of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ 89 erson 6:10 PM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner **ckaltimore** 10W Son 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. **Director** 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State City, Town or Location 10d. Inside City Limits Directo Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 usa monn 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Slack 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Fork lift Operator 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Operator Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type, Print) Raymonn Fiance Baltimore .inda 20a. Method of Disposition 20b. Mape of Wife of the Cemetery 20c. Location - City or J 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Insee 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Morithi Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 ed by the attending p detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year J Yes 2 ☐ No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ CHERST 1 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) 2 No ပ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) works ST POWSUN CHMIRS ANION 31. Date filed (Month, Day, Year) AUG 17 32 Registrar's Signatur

State Registrar

Medical

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Year 5:45 PM AUGUST 2009 13 BETTY LAW JOHNSON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOSEPH RICHEY HOSPICE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🕱 F Months Hours MARCH 27,1915 NC 94 220-14-6244 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County X Yes 2 No BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1901 ELGIN AVENUE APT. 209 21217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) REGISTRAR THEOLOGY 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CARRIE WHITFIELD J.P. LAW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) APT. 209 HERMAN JOHNSON/HUSBAND 1901 ELGIN AVE. BALTIMORE, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) GARRISON FOREST CEM. 8-21-2009 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jacob (Lisease of injuly that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THURDIDISM 1 Yes 2 No 3 Probably 4 Unknown FIBRICLATION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician/Medical 9 Completed Be Certification: To

4 Homicide

29a, Certifier

29b. Signatur

Examine

director,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaniner must be notified at once.

**Physician** /Medical

Examiner

Maryland 21215-0036

altimore,

sician and burial-transit attending physician for use as the buria signed by the a has Hospital or Attendi 24 hours after death. Funeral Director: completely filled in by the To the Hospital of within 24 hours and To the Funeral D

Records,

Division of Vital

State Registrar

DHMH 17 Rev 1/2001

Medical

and hanner stated

29c. License number

30. Name and address of pe

Month, Day,

Excertifying Physician: To yie best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician : 45 AM RANCES 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore of Hospital 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Gountly) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗗 🕇 210-10-9659 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 27 is marked any injury or other traumatic event, the Medical Examination and once. 1 des 2 No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Jackson, 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 ■No 21215-0036 Specify. þ 3 Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental ျှ 19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) URGU/A
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Pages 1 ment of h 1 Burial 2 Cremation 3 Removal from State 4 □ Donation / 3 □ Other (Specify) permit. 21. Signature of Funeral Service Licensee 23a. Part I / Enter had seas, or complications that caused the shoot, or boar allure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or ndition resulting in death) Severe months **Physician** Hostic /Medical Due to (or as a consequence of) Examiner month dvanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Coronaly Ast Due to (or as a consequence of): sician and burial-trans To the Hospital or Attending Physician: The law requires that the death certificate be execuvithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a □Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 💢 No **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 ☐ Yes 1 Na Inpatient 2 National ER/Outpatient 3 National DOA After this funeral c 28d. Describe how injury occurred 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16 2009 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospita Battimore, 2401 W. Belvedere Abgalan inth, Day, Year) 31. Date filed (Month, Day, 32? Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh g894 8-21-09 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** <u>Virginia</u> M. Johnson 5 1 aum 2009 /Medical 11 Aug. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Future Care Old Court f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2√2 F 220-12**-**7202 1920 MD Director 25. Sept. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Iho Medical Examinan must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7014 Rockland Avenue 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify ģ Specify: Black 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>11th grade</u> Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Jackson, Sr. Rosa Burley 19a. Informant's Name/Relationship (Type. PrintBrother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)

5208 Depmore Ave Baltimore, Md. 21215 Alexander Jackson, Jr. 20b. Place of Disposition (Name of Arbutus Mem • Park 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/17/09 Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, MD 21215 Approximate Interval Between Onset and Death 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 **Physician** EPSIS /Medical Due to (or as a consequence of): Examiner SACRAL DECUBITUS INFECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner BARBE attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, the death certificate be Physician/Medical NUTRITION 207612 as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.0. ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð LEBROVASCULAR ACCINE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No VASCULAR 24a. Was an cate has page 2 s autopsy performed' certificate 1 □Yes 2 LaNo DEMENTIA or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 2 this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Matural 5 Pending investigation within 24 hours a er dea h.

To the Funeral Director A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP 00061439 とうり

State Registrar 31. Date filed (Mg

M-D

5311 OLD COURT RD,

BALTIMONE, MI) 21132

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOSANYA

32. Registrar's Signature

16mis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical of Death or Location of Death Examiner E 57 1101 f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Days Min. 1 № M 2 □ F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the 16st of the 18st of the 10a 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Numbe Funeral 14 Bace - American Indian. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White etc 2 Married 1 Never Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1962 -/966 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO MOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 19b. Mailing Address (Street and Number or Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatu Fund al Service Licensee 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): and signed by the attending physician 1 be detached for Use as the burial P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 A Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**o 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29b. Signature and title of pertifier Genne 29d. Date signed (Month, Day, Year) 29c. License number onsagra 30. Name and address of person who completed cause of the (Item 23a) (Type, Print) 645GC 0 31. Date filed (Month, Day, Year) istrar's Signature State AUG

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 13<sup>Day</sup> 2009<sup>Ye ar</sup> **Physician** Eva M. Kelly 8:08 PM M August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Columbia Ahatul Care Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2XXF 93 Bartlett, NY Director 118-10-7977 May 23, 1916 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Experiment must be notified at ury or other traumatic event, the Medical Experiment must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Howard Columbia Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21045 USA 8518 Wind Dance Way by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 ♥ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Storey 17. Father's Name (First, Middle, Last)
Frank S. Walker Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6171 Silver Arrows Way, Columbia, Maryland 21045 19a. Informant's Name/Relationship (Type. Print)
Dawn Creek-Daughter permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. 000ce. 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/19/2009 Clinton, NY 21. Signature of Funeral Service L cense 22. Name and Address of Facility Witzke Funeral Home, Inc. 101283 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part 1. Enfer the disease, Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Altero Sclevolic Cardio Vas Calar DIRCUSE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of, Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 sl 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) group hank 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completely fil Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 15 2009 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Neck Road Baltimore Maryland 21221. Sabapalhi

State Registrar

DHMH 17 Rev 1/2001

Kamesh

32. Registrar's Signature

			Please	Type or Print in B State of Maryland						gible.	26119	
		•	State Registrar		Ce	rtificate of	Death	Re	eg. No.			
	Di vivi		1. Decedent's Name (First, Middle, La	ast)				Date of Death     Month	n Day	Year	3. Time of Death	
п	Physici /Medic		N	Mattie Louise	Levi	inskas		August	11,	2009	7:20 A M	
	Examin		4a. Facility Name (If not institution, gi				or Location of Death				nore Co.	
			2813 Moorgate F	Road Sex 7. Age (In yrs. I	ant hirthday	) If Under 1 Year	dalk  I If Under 24 Hrs.	8, Date of Birth			place (State or Foreign	
	Funeral Director			1 □ M 2 🖾 F 82	Yrs.	Months Days	Hours Min.	July 26	,1927	Ind	nty) liana	
	land ow		10a. State 10b. County	10c. City	y, Town or L	ocation					10d. Inside City Limits	
	Mary -f sh	tor	Maryland H	Baltimore		Dun	da1k				1 ☐ Yes 2 X No	
	r 28a	Director	10e. Street and Number	Jan 10 International Control of the		10f. Zip Code		10	0g. Citizen	of What Cou	intry?	
	h with		2813 Moorgate	Road			21222 Unit			ted St	cates	
36	within 72 hours after death with the Maryland John. John. r than "natural", or Items 23a or 28a-f show the Medical Examination to the Medical Examination.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U. Armed Forces? 1	S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		Race - Ameri Black, White, ecify:		
21215-0036	hours tural		3   Midowed 4 □ Divorced  15. Decedent's E	Year or Dates:	16a Dece	edent's Usual Occu	nation		16b. Kind o	of Business/Ir		
15	in 72 t	Completed	(Specify only highest g	rade completed)	(Give	e kind of work done DO NOT use retire	during most of worked)			•		
212	within giene.	Eo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Years Meatcutter Groce								ry	
	it it	BeC	17. Father's Name (First, Middle, Las	it)				ne (First, Middle, N	Aaiden Suri	name)		
ılar	should be tand Mental s marked o	To E	Charles Jackson				Lola	Bocock				
e, Maryland		i	19a. Informant's Name/Relationship (Type. Print)  Patricia J. Whitlow(Daughter)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2  2813 Moorgate Road Dundalk, Maryland								ip Code) 21222	
Baltimore,	Pages 1 and 2 ment of Health ant: If item 27 is ury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 L  Donation 5 Other (Spec	Removal from State	emetery, cre	osition (Name of ematory or other pla of Faith				ion - City or T	own, State Maryland	
Balti	permit. Pages Department of Important: If it any Injury or once.		21. Sign ture of Funeral Service to		7		k Funeral se Ave. I				Inc. 21222	
			23a. Part 1 Enter the disease, or cor	mplications that caused the death	n. Do not er					·	Approximate Interval Between	
	Physician	6 7	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									
2000	/Medical		disease or condition resulting in death)	Due to (or as a consequence	uence of):							
1	Examiner			ASC	VD							
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	uence of):							
	executed n and ial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	С								
30,		_	resulting in death Last	Due to (or as a consequ	uence ot):							
68760	ficate be e physiciar s the buris	dica	•	d								
O. Box	that the death certificate be ned by the attending physicis detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnating the second of the secon	I death 3	☐ Ectopic pregnan	ю		23d	. Date of deli Month	very Day Year	
ds, P.	ളെ	è	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause gi	iven in Part I.				the cause of death?	
Vital Records,	e r ge	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No							prior to c death?	topsy findings available completion of cause of		
ita	slan: T ertificat ctor, pa	Be C	25. Was case referred to medical					ath (Check only on				
of V	nysic iis ce direc	일	examiner? 1 □ Yes 2 🗡 No	Hospital: 1 ☐ Inpatient 2 ☐		ent 3 1 DOA		lome 5 🔼 Reside	ence 6	]Other (Spec	cify)	
ion o	inding Phath. r: After the funeral	ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year) on	28b. Time Injury	Wo	uryat ork? ⊒Yes 2 □ No	28d. Describe ho	ow injury od	curred		

Division To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
08/12/200 29c. License number D0024303 CON DE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mukech / Whar May 3509 East Baltimore, MD 21224 350 32/Registrar's Signature.

Medical Certificat

3 Suicide

29a. Certifier (Check only one)

4 🗌 Homicide

29b. Signature and title of certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** August 6, 2009 7:49 AM M Wanda L. Loose /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Emerald Estate Assisted Living Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year) Nov 3, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 1 7 F Director 86 197-14-5434 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 3855 Greenspring Avenue Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 0 12 <u> Armco Steel</u> 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe eny lighty or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) Be Ira Lantz Amy DeWitt ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t9a. Informant's Name/Relationship (Type, Print) Linda Letourneau/daughter 6609 Birchwood Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Walder 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atheroscleratic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. sete has been signed by the capage 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificete 2 XNo 1 Yes Physicisn: : After this certifical funeral director, 25. Was case relerred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Attending Injury 1 Natural 5 Pending 1 Tes 2 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide ō To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certified 028987 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPERLING 5601 BALTO LOCH RAVEN 32 Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1859 /Medical Town, or Location of Death Eacility Name (If not institution, give street and number Examiner HOSPICE 45e line If Under 1 Year 6. Sex Social Security Number vrs\_last birthday) Funeral Months Days Hours Min. 1 □ M 2 🗷 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f st any injury or other traumatic event, it is item Fraumatic event. Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 Ho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 <mark>□N</mark>o 3altimore, Maryland 21215-0036 Specify: MITICEL ۾ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working to Do NOT use revied) Housewite Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First Middle, Last) Be ane ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19a. Informant's Name/Relationship (Type. Print) Catoctin 20c. Location 20b. Place of Disposition (Name of cemeter), cremated or other 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State (ano 4 Donation 5 Other (Specify) 21. Signature of Fund al Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, theart failure. List only one cause on each line Approximate Interval Between Onset and Death 23a, Part 1. Immediate Cause (Final disease or condition resulting in death) 0 Physician /Medical Due to (or as-a Examiner Sequentially list conditions, Due to for as a Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 0 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, Year)
AUG 1 7 2060 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 8:09 P M August 9 2009 Eleanor Mae Lawrence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 4,1918 Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours Months Days 1 □ M 2 🖫 F Maryland 90 220-05-0187 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director New Windsor MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21776 601 S. Springdale Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify: Specify: White þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence E. Rippeon ဂ Charles Edward Garber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 S. Springdale Rd. New Windsor, MD 21776 Nancy Smith/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 8/12/09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) hu e of Buneral Service L 22. Name and Address of Facility Hartzler Funeral Home affarine C 310 Church St. New Windsor, MD 21776 he mode of dying such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of). Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 2 □ No 1∐Yes 2∭ANo 1 □ Yes 25. Was case referred to medical examiner?
1 A Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit P.O. Box 68760. attending p signed by the a Division of Vital Records, s certificate has t irector, page 2 sl r this certific ral director, After after death.

Director: Af d in by the fur

**Funeral** 

Director

show

ral", or items 23a or 28a-f shov Econing regist be actified at

"natural"

tal Hygiene. d other than "nature event, the Weden E

item 27 is marked other traumatic ev

Department of Health a Important: If item 27 is any injury or other trau

**Physician** 

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Certification: To

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

within 24 hours a

To the Funeral E

completely filled i the Hospital

State Registrar

Medical

address of person who completed C X (Month, Day, Year)

AUG 17

5 Pending investigation

6 ☐ Could not be

cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated

8/8/09

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☑ No

29d. Date signed (Month, Day, Year)

Fell from standing position

28f. Location (Street and Number or Rural Route Number, City or Town, State Taney town, MD

3217 Bert Koontz'Rd

manchester, moznoz

1830

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25123 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:20P Martin 09 Frank August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NA Baltimore BonSecours Hospital 8. Date of Birth
(Month, Day, Year) 9. Birthplace (State or Foreign Country) VA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 XM 2 □ F 96 226-10-8502 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f shov 28a-f show 1X Yes 2 No Director NA Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 2047 N. Bentalou Street Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etcAfrican Armed Forces?
1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: American If Yes, Give 3 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) within 72 Stream Fitter Trade Union College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic. Elementary/Secondary (0-12) Longshoreman 5th Grade 18. Mother's Name (First, Middle, Maiden Surname) Unk. 17. Father's Name (First, Middle, Last) Be Mary S. Martin ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box #3043 Baltimore, MD 21229 Shirl V. Duncan-Grand 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Wall Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, MD 08-22-09 King Mem PK. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenson 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): execute sician and burial-trans Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Partyl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sease autopsy performe certificate I 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🗷 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural s after death.

I Director: After in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

OM, VHONAS 31. Date filed (Month, Day, Year) AUG 1 2009

29b. Signature and title of certifier

940 W. BALTIMORE 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHYJICHAY

29c. License number

57543

S.T.

29d. Date signed (Month, Day, Year)

BALTIMORE, MO 21223

-17-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd Items 23aFate of Markland | Department of Department of Death | Reg. No.

			1- For Amend Items 23ad	tr,25,28	a≕i perm Cer	te, g894,0	Death	<b>D</b>	Reg. No.	13 601	4
	Physici	an	1. Decedent's Name (First, Middle, Last)	DANKA	mille			2. Date of Dea Month	Day	3. Time of De	
	/Medic	cal	4a. Facility Name (If not institution, give street		inville		Location of Death	July :	30 200 4c. County o		,
	Examin	ıer	Carroll Hospital Ce			Westmins			Carrol:		
	Funeral Director		5. Social Security Number 214-38-3752 6. Sex 1 □ M		n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April	h y, Year) 2 1928	9. Birthplace (State or I Country) Canad	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo					10d. Inside City	Limits
	a-fsh	ctor	MD Carrol1		Sykesví	11e				1 □ Yes 2	:□ <b>X</b> io
	th with the 23a or 28 ust be no	ral Director	10e. Street and Number 1265 Buckhorn Road			10f. Zip Code 21784			10g. Citizen of Wi	hat Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Modical Evorrine must be neithed at once.	d by Funeral	1 Never Married 2 Married	Nas Decedent Eve Armed Forces? I ∐Yes 2 ☑ No fYes, Give X rear or Dates:		Nas Decedent of H fYes, specify Cuba I∐Yes 2∭(No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black Specify:	- American Indian, White, etc. white	
Maryland 21215-0036	vithin 72 h	Completed	15. Decedent's Education (Specify only highest grade control Elementary/Secondary (0-12)	n mpleted) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired Shier	ation during most of work d)	ing   grocery			
N.	filed v Hygie other 1		17. Father's Name (First, Middle, Last)		Ca	PHIEL	18. Mother's Name	e (First, Middle,	Maiden Surname	p)	
/lan	uld be Mental Irked c	To Be	John Prodanick				Kather:	ine Watı	rych		
, Mar	and 2 sho salth and I 1 27 is ma er traums	ľ	19a. Informant's Name/Relationship (Type. Charles Moranville (		1		and Number or Rur Rd., Syke		, MD 2178	84	
Baltimore,	iges 1 and of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remail	ovai from State	20b. Place of Dispo- cemetery, cren		10/	Date		City or Town, State	
	nit. Pa artmer ortant injury		4 Donation 5 Nother (Specify) er  21. Signature of Funeral Service Licensee	tombment	Lake Vie	w Mausole . Name and Addre	ss of FacilityHaid		Sykesvil	e & Chapel	
ñ	Per Imp any		Daige Harget	Herbe			195 Sykes			e w Ghaper	
100	Physician		23a. Part 1. Enter the disease, or com, licati shock, or heart failure. List only one c Immediate Cause (Final disease or condition	ons that caused the ause on each line.	death. Do not ente	er the mode of dyin	ng, such as cardiac cerebral	or respiratory <i>a</i> <b>Hemorrh</b>	rrest, Lage	Approximate Interval Betwee Onset and De	een eath
	/Medical Examiner	ı	resulting in death)	Due to (or as a co	onsequence of):	pertensi	ve Cardio	vascu1a	r Diseas	se	
		Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):				, ,,	-	
	rificate be executed ig physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Desta factoria de			CERTIFICATIONA	W)	OUCH EXAMINER	4	
68760,	be ex		resulting in assum, Euch	Due to (or as a co	onsequence oi):		-TONTION A	PPROVED BY ME	Dione -		
89	rtificate be executed ng physician and as the burial-transit	Medical	a			-	CERTIFICA				
go.	death ce e attendii d for use	Physician/N	in the past 12 months?	If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnand Other <i>(specify)</i>	у		23d. Date Mon	e of delivery hth Day Ye	ear
ecords, P.	requires that the reen signed by th nould be detache	ρ	Part II. Other significant conditions contrib	uting to death but n	ot resulting in the ur	nderlying cause giv	en in Part I.		1.2	ibute to the cause of dea	
Hec	The law re cate has bee page 2 sho	Completed						24a. Was autoj perfo 1 □ Yes	osy p rmed? d	Vere autopsy findings avrior to completion of cau eath? □Yes 2	vailable use of
VITA	Physician: this certific al director, I	BB	25. Was case referred to medical examiner?	ital: . — .		. a□ BCA Oth	26. Place of Deat	h (Check only o	nne)		
0	g Physer this eral di	일	27. Manner of Death	1 inpatient	2 ER/Outpatien 28b. Time of	28c. Injur	4 ⊔ Nursing Ho		dence 6 Other	(-)	
NO N	ending sath. or: Aft he fun	atio	5 Pending investigation	1-30-69	ear) Injury	M 1□	Yes 2 No	FOH N	· buthro		
DIVISION	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury building, etc. (	At home, farm, stre	eet, factory, office		City or 101	Street and Number vn, State)	er or Rural Route Numb	er,
-	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  Check only 2 Medical Examiner:	an: To the best of n On the basis of ex and manner stated	amination and/or in	vactination in my o	ninion death occur	red at the time	date and place a	and due to the cause(s)	
	To t To tl	ž	29b. Signature and title of certifier  M.M. 2			29c. Licens	e number		29d. Date signed	(Month, Day, Year)	
				atad sauge of do-1	h /ltom 02=\ /Tim-	Drint)	7681		1-50	-0-1	-
			30. Name and address of person who comp  M. M Levay 13	1/3	ress Wal	, Saite	e 114 !	Eldenbu	ing mo	21784	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 13 2009	32. Registrar's	Signature ba	Rad			J	(Month, Day, Year) -09 -71784	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1312 Physician 2009 OM tugust Thomas E. Martin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. unk 57 31, 1952 Mar 223-74-6596 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2√ No Director MD Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21740 USA 453 McDowell Avenue Funeral . Was Decedent Ever in U.S. UNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? unk 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Tes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: White Specify. à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk, unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21740 permit. Pages 1 and 3 Department of Health Important; If Item 27 any injury or other tra once. Washington County Hospital 251 E. Antietam Street Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5∰other (Specify) in state 21. Si nati e of Euneral Service Licensee Roma Ld S. Made de birector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final tion 140 CORDIAL 12/A126710N disease or condition resulting in death) Due to (or as a consequence of): CORDANNY ARTEN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident

requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, To the Hospital or Attending Ph within 24 hours are death. To the Funeral Director After th completely filled in by the funeral

Certification: To

Medical

**Funeral** 

Director

filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show

12 should be filed with and Mental Hygier 7 is marked other th

Pages 1 and 2 s ment of Health ar ant; If item 27 is

**Physician** 

/Medical

Examiner

physician and the burial-tran and

attending pl

ed by the a

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page 2 should

certificate has

After this certification funeral director, I

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

one) 29b. Signature and tile of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

6 ☐ Could not be determined

10 Vm

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue Hageistown 32. Aegistrar's Signature

State Registrar 31. Date filed (Month, Day, Year) AUG 17

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 25tate of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 25tate of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) Year **Physician** Stanley William Miller Sr. AUG 08:00 PM 2009 04 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death HOSPITAL BALTIMORE ST. AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth Month, Day, Year) 8/16/1921 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 212-18-8265 1 XM 2 ☐ F 87 Director Yrs. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Evanting it gat be notified at MD Baltimore Catonsville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Ln, RGT 6109 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: white þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) sho Id be filed within 7 and I ental Hygis ne. s marked other han "n College (1-4or 5+) Elementary/Secondary (0-12) United Iron & Metal Foreman Baltimore, Maryland 17. Father's Name (First, Middle, Last) l and 2 sho Id be fi Health and hental H Robert T. Miller permit. Pages 1 and 2 sho is Department of Health and its Important: If item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Lola Sullivan/Daughter 505 S. Hammonds Ferry Rd. Linthicum, MD 21090-2412 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 8/8/2009 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Fundral Service Licens 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SUB DURAL HEMATOMA DAYS /Medical resulting in death) Due to (or as a consequence of) Examiner ROVED BY MEDICAL EXAMINER Sequentially list conditions, cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of) burial-transit CERTIFICATION AF Due to (or as a consequence of): physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 0 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CORONARY 24b. Were autopsy findings available prior to completion of cause of death? ARTERY DISEASE 24a. Was an autopsy performed certificate Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Physician: 25. Was case referred to medical examiner?

1 X Yes director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this oţ in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 2 Accident May, 2009 Unknown M 1 ☐ Yes 2X No Subject fell out of bed. 24 hours after death Funeral Director: 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 709 Maiden Choice 4 Homicide Lane, RGT 6109, Catonsville, MD Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mallila. A M.D P22257 AUG 45 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, 900 S. CATON AVENUE BALTIMORE, MD - 212 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 132009 Jeneur Barke. Registrar

DHMH 17 Rev 1/2001

SOTH THANK

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STANLE

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State of Maryland / Department of Health  State  Certificate of Death  Certificate of Death			ene 3. No.2	26127						
	Physicia	n	1. Decedent's Name (First, Middle, Last)  Ellen C. Ohly		Date of Death	12° 20°09	3. Time of Death 10:15 рм						
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	n of Death		4c. County of Death							
	Funeral		J. Social Security Number 0. Sex 7. Age (17 7/3, last birthday) Months Dave Hours	er 24 Hrs. 8.	Date of Birth (Month, Day, ) Une II,	Baltimore	place (State or Foreign htry) NOSIOvakia						
	Director		077-24-3400 1□ M 2⊠ F 90 Yrs. Months Days Hours Usual Residence of Decedent	J	une II,	1919 Czec	Moslovakia						
	aryland show d at	7	10a. State 10b. County 10c. City, Town or Location Pikesville				10d. Inside City Limits 1 ☐ Yes 2 X No						
	with the M a or 28a-f be notifie	Director	10e. Street and Number 22 Breton Hill Rd Apt 1A 21208		100	g. Citizen of What Cou							
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★ No If Yes, Specify Cuban, Mexicant Specify		y Yes or No- can, etc.)	14. Race - Ameri Black, White Specify:							
215-0036	n 72 hour ''natura' edical Ex	Completed b	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mo	nost of working	10	6b. Kind of Business/Ir	ndustry						
7	ed withii ygiene. ier than t, the M	Comp	Elementary/Secondary (0-12) College (1-4or 5+) Human Resource Dep	pt.	E	Banking							
land	₹ 5 55 Q	To Be	The latter of table (1904) sheets, and	iners Name (F laria	Liebr	aiden Surname) echt							
Maryland	12 should n and Men ris marke raumatic	-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Num.										
	ages 1 and 2 should b nt of Heath and Ment :: If item 27 is marked / or other traumatic e		Mr. D. Christopher Ohly/ Son 5714 St. Albans W  20a. Method of Disposition (Name of cemetery, crematory or other place)	Date Date		Oc. Location - City or T							
altimore,	permit. Pages Department of Important: If it any Injury or o		4 Donation 5 Dotter (opecity)	8-14-0		Towson, N							
Ba	Depa Impo any I	(i. ).	1050 York										
	Dhysisian	N 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line.  Immediate Cause (Final disease or condition  a.  Toulure										
	Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):			-	man						
		ner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury										
χ σ	ficate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
58760,	icate be physicia s the bu	dical	d										
Division or Vital Records, P.O. Box (	eath certi attending for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 menths?  1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			23d. Date of deli Month	very Day Year						
ds, P.	w requires that the deben signed by the should be detached	δ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	art I.	23e. Did tob	acco use contribute to	the cause of death?						
SCOL	aw requisible been 2 should	Completed	Debility		24a. Was an	24b. Were au	topsy findings available ompletion of cause of						
a	ician: The lav certificate has rector, page 2 a		J Company of the last of the l	lear of Decile	perform 1□ Yes 2	death? No 1 ☐ Yes	2□ No						
r Vii	ding Physician; n. After this certific funeral director,	To Be	examiner?  1 Yes 2 Mo  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4	Nursing Home		nce 6 □Other (Spec	eify)						
o uo	nding P th. : After tl s funera	tion:	27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2		d. Describe ho	w injury occurred							
Divisi	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,						
,	the Hospital or A hin 24 hours after the Funeral Dire mpletely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, or and manner stated.	dante converse	d at the times de	sta and alone, and due	to the equipo(e)						
5	To the within 2 To the comple	Med	29b. Signature and title of certifier 29c. License number	er	29	d. Date signed (Monti	n, Day, Year)						
)			30, Name and ordress of person, how mpleted cause of death (Item 23a) (Type, Print)	544	C	08-13-	2009.						
		V A	Susan Amery 6565 N. CHARLES ST. S.	TE 410	5 To	wsm Hd	21204						
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200 9 Year Month **Physician** ugust 1045 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Woshington Medical Center
5. Social Security Number 16 Say 17 Age 11-Anne Arunde Glen Burnie Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Usual Residence of Decedent 10b. Cou 1 □ M 2 💢 F Months Days Director Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10d, Inside City Limits 10b. County 10c. City. Town or Location 28a-f show Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 Yes 2 No Director MOTE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 NNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Ŋ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ses 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last, Be 19a. Informant's Name Pelationship (Type. Print) Juliand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, lemen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State eenMount 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Ave. Balto. 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1-Ail IVEN /Medical Due to (or as a consequence of): Examiner Alcohol Associated Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). sician and burial-trans Due to (or as a consequence of): of Vital Records, P.O. Bóx 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Uneral Director: After this certificate has b completely filled in by the funeral director, page 2 sh 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Washington Medical Center 175more

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 17 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 125, Maryland / Department of Heelth and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9<sup>Day</sup> **Physician** 2009 6:18 P™ Deborah Paredes August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford 423 Crisfield Drive Abingdon If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) August 14, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Pennslyvania 1 ☐ M 2 🕱 F 51 Yrs 154-56-4093 **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Wedfoal Evant or other traumatic event or other event 10a. State 1 ☐ Yes 2 ☑ No Director Maryland Harford Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21009 U.S.A. 423 Crisfield Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Travel Travel Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Enos W. Fullerton Ednamae T. Buck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eulo Domingo Paredes / Husband 423 Crisfield Drive, Abingdon, Maryland 21009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-15-2009 New St. Mary's Bellmawr, New Jersey 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC NON SMALL CELL LUNG CANCER 17 MONTHS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a, y, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or AttendIng Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 NORTH BROADWAY

Hidle, M.D.

0066 034

MD 21231

AUGUST 10,

2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** William Phelps August 2009 1:18 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7301 Summerwind Circle Laurel Prince Georges 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. 93 Yrs 1916 June 6, Director 184-07-5071 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Everning or other traumatic event events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Funeral Director 1 ☐Yes 2 No Prince Georges Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7301 Summerwind Circle 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 □Yes 2 ☑ No Specify: Specify: black Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University Administrator College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Ε. Phe1ps Jennie Mae Harris ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yoshiko Phelps / son 7301 Summerwind Circle, Laurel, MD 20707 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 Removal from State August 16 Atlantic Crematory 4 Donation 5 ☐ Other (Specify) Glen Burnie, MD 2009 21. Signature o Funeral Serve Licen 22. Name and Address of Facility
Fleck Funeral Home, INC. MU1283 7601 Sandy Spring Road, Laurel, MD 20707 23a, Part 1. Enter the disease shock, or heart failure. complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Lis Immediate Cause (Final **Physician** rall year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dué to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Mary		artment of H			ene 19. No. 2 0 0 9	26131	
	7		Decedent's Name (First, Middle, Last)	)				2. Date of Death	1	3. Time of Death	
	Physici		Richard Lee	Price				Aug 11	2009 Year 11:30 P M		
275.00	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Death			4c. County of Dea	th	
	LXdiiii		Genesis Healt	h Care		Luthe	erville	Baltim	ore		
	Funeral		Social Security Number     6. Security Number		yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9. Bit	thplace (State or Foreign ountry)	
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	pu ,		Usual Residence of Decedent	140	c. City, Town or Lo					10d. Inside City Limits	
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	or 2	<b>Funeral Director</b>	10e. Street and Number	211		10f. Zip Code		10	og. Citizen of What C	ountry?	
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	er de Items	aue	Titi Mariai States	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	Black, Whi		
5-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	ð	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify: W	nite	
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Baltimore,	Pages hent of hent. If ite		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cre Evergre	matory or other plac			Finksbur		
Balti	permit. Departri Importa any Inju		21. Signature of Funeral Service Licens	Je Flite	In 14 25		ss of Facility $ ar{F} $	letcher	Funeral	Home, P.A MD 21157	
20	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a co	ru tivn prisequence of): estive	ter the mode of dyir	ng, such as cardiacon such as	c or respiratory arre	est,	Approximate Interval Between Onset and Death	
0,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):	CAY FE	2/2/2	disee	ye 11.0.1.		
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o uoi	ng fte ine	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wor	ry at rk? Yes 2 □ No	28d. Describe ho	ow injury occurred		
Divis	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or i n, State)	Rural Route Number,	
	le Hospit 124 hours le Funers letely fille	Medical C		rsician: To the best of miner: On the basis of example and manner stated	amination and/or in						
	To th Within To th COMP	Ň	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)	

29b. Signature and title of certifier

29c. License number

Registrar's Signatur

TOWSUN,

State

Registrar

DHMH 17 Rev 1/2001

		Pleas  1 _ For 1 _ State	State of Ma		Depa	artment of H	lealth a	and Mental H	ygiene		06106
		Registrar	fAl		Cei	rtificate of	Dealli	2. Date of D	Reg. No.	7117	3. Time of Death
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/Medic		4a. Facility Name (If not institution,		14-		4b. City, Town, o	r I ocation o			County of Dea	
Examin	er	FRANKLIN	SQUARE H	105 P27				2MORE	] ]	Baltimo	re
Funeral Director		213-84-3139	5. Sex 7. Age 1  M 2	49	Yrs.	Months Days	Hours	Min. (Month, E	lav. Year)	) Ma	thplace (State or Foreign ountry) ryland
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation	-				10d. Inside City Limits
Mary a-f sho	ţċ	MD Baltin	nore	No	ttin	gham					1 □Yes 2√ No
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d be i	o Be	John Martin D				Barb	ara Ann De	iler	, and the second		
shoul nd Me mark	ဥ	19a. Informant's Name/Relationshi	p (Type. Print)	19	b. Maili	ng Address (Street	and Numbe	er or Rural Route Num	ber, City o	or Town, State,	Zip Code)
alth a 27 is		Joyce Baker/si	ster	3	48 (	Central A	venue	Glyndon,	MD 2	21071	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☒ Donation 5 ☐ Other (Spe		20b. Place cemer	of Dispo ery, cre	osition (Name of matory or other pla	ce)	Date	20c. Lo	ocation - City or	r Town, State
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	-	23a. Part1. Enter the disease, or c	omplications that caused	the death. Do		altimore, ter the mode of dyi			arrest,		Approximate
Physician		shock, or heart failure. List o immediate Cause (Final disease or condition resulting in death)	niy one cause on each lin	e. SAST		CANO	SR				Interval Between Onset and Death ON KNOW
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nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	e of):						
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physi physi the b	dic		d								
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal dea		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			23d. Date of de Month	elivery Day Year
that the de ned by the	y Phy	9 ☐ Unknown  Part II. Other significant condition	s contributing to death bu	ut not resulting	in the u	inderlying cause gi	ven in Part I	. 23e. Die	d tobacco	use contribute	to the cause of death?
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Physic! this cer al direct	0	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/0	Outpatie	nt 3□ DOA Oti	ner:	ursing Home 5 ☐ Re		6 □Other (Sp	ecify)
nding Ph th. : After th e funeral	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga			Time o	Wo	ry at rk? ] Yes 2 □	28d. Describ	e how inju	ry occurred	
Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, tely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could no determin		ury - At home, c. (Specify)	farm, st	reet, factory, office			(Street al Гоwп, State		Rural Route Number,
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the best of taminer: On the basis of and manner sta	examination	ge, dea and/or in	th occurred at the to	ime, date ar opinion, dea	nd place, and due to the time at the time.	ne cause(s ne, date an	s) and manner and place, and di	as stated. ue to the cause(s)
To the within 2 To the complet	Mec	29h Signature and title of certifier			_	29c. Licen	se number		29d. Da	ate signed (Mor	nth, Day, Year)
F>F0		John Ho!	Harathi/	M	.0	.	69	198	AU	GUST,	12, 2009

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN KO11 HP7 H2 L, 9000 FRANKLIN SQUARE DRZVB, BAL 72 MORE, 2123 7

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G894 8/18/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 23:45PM Ross MINNIE 04, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No Howard **Funeral Director** Columbia 10g. Citizen of What Country? 10e. Street and Numbe Green Mountain Circle U. S. A. 10629 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Home maker Owned 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First. Middle, Last) Be P 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clarksyille, M.D. 21. Signature of Funeral Service Licenses Bultimore, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician RESPIRATORY FAILURE 15 MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HOURZ EREBRAL HERNIATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to the Hospital or Attending Physiclan: The law requires that the death certificate be executed INTRAPARENCHYMAL HEMORRIHAGE Due to (or as a consequence of) attending physician a for use as the burial-Records, IP.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 2 **2** No 1 Tyes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 04, 2009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RYAN FELLING M.D., Ph.D. 4940 EASTERN AVENUE BALTIMORE, MD 21224 31. Date filed (Month, Day, AUG 17 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 1410 MIGE 08 -mma 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 8/13/1927 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2**X** F 81 Maryland 217 22 1338 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1X Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21001 767 Custis St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Education 12 Food services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank I. Thompson Pearl I. Mull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 77 Smith Ave, Aberdeen, MD 21001 William S. Riley (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/17/2009 Bel Air, Maryland Bel Air Mem. Gdns. Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANDIOGENIC SHOCK Due to (or as a consequence of): PNEUMONIZ DILATERAL Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 201 NO 1 ☐ Yes 1 ₽ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

the death certificate be executed P.O. Box 68760, Division of Vital Records, Attending Physician:

ate has been signed by the atte page 2 should be detached for To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I To the within 2

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot Injury or other traumatic event, the Madical Exprainer is ust by nother

Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, The Man

**Physician** 

Examiner

and

attending physician

as

Physician/Medical

Be

Certification: To

Medical

29a, Certifier

/Medical

Funeral

Completed

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

AUG 17

Ardu Nondemo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HNPLW Non Akerski MD 32. Registrar's Signature

35 FULFOXO ATE BEZAR, MOZOLY

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** D. 5:15P <sup>M</sup> Arlie Sharp 12, 2009 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Dundalk 2413 Meadow Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □XM 2 □ F Yrs 232-26-9696 93 26,1915 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Maryland Dundalk Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 2413 Meadow Road United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 Is marked other than "natural", or items traumatic event, It e I colour Example m 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. fXXYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married XX Married 2 □ No Baltimore, Maryland 21215-0036 1 □Yes 2\\X\No Specify: à 3 Widowed 4 Divorced WWII White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Lucy Sarah Underwood Creetus Herndon Sharp ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2413 Meadow Road Dundalk, Maryland 21222 Mrs. Elizabeth Ann Sharp(Wife) Department of Health Important: If item 27 any injury or other troope. 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery 8/17/2009 | 4 ☐ Donation \_ 5 ☐ Other (Specify) Marlington, WV 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave, Dundalk, Maryland 21222 21. Signature of Funeral Service Licenses 22 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician Minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner month Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physiclan; The law requires that the death certificate be executed Exami physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 ☐ Probably 4 ☐ Unknown 2 NO 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 st autopsy perform 2 No 1 ☐Yes 2 ☐ No 1 □Yes this certific al director, 25. Was case referred to 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner Death 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 atural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 10057021 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 Philadelphia Rd Stelor, Balt. MD 21237 M.D Rita Mathur, Year) 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2 05AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Salhmore new lave more If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Sex **Funeral** Year) Min. Months Days Hours 1 □ M 2 🔀 F 218-26-3351 79 3,1929 Director Oct. North Carolina Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at 28a-f shov 1 ☐Yes 2X No Directo Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 226 St. Helena Ave. Funeral "natural", or items 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 ▼ No Specify Specify: 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Yeast Manufacturing Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Company 12 Years Dispather 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance in and Mental I ပ္ Ben Simmons Alice Elliott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any Injury or other trau Mr. John Sexton (Son) 202 Patapsco Ave. Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date r⊞Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. 8/17/2009 Bel Air, Maryland 22. Name and Address of Facility 21. Signature of Fun Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 MONH /Medical Due to (or as a consequence of): Examiner うりょ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): requires that the death certificate be executed burial-transit Examir and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown as been signed by the should be detached 23e. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð Ves 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? law 1 24a. Was an this certificate has page 2 autopsy The perform 2 □ No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 NO 1- Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the full 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Name and add ess of person who

Year)

31. Date filed (Month, Day

Ba.

503

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

214

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 8 State of Marylands / Carlos Registrar	partment of Health and N <b>72010dhb</b> ertificate of Death	lental Hygiene	2009 26137
			Registrar  1. Decedent's Name (First, Middle, Last)	Jimouto of Louis	2. Date of Death	3. Time of Death
	Physici		Lillian Schmidt		Month Day August 1	1 2009 10:52 PM
e., 95	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
di	Exami		Gilchrist Hospice Care	Towson		Baltimore
	Funeral	0	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		219–18–6057 1□ M 2덫 F 85 Yrs.	Months Bays Hours Min.	11/30/1923	Maryland
	nud w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	laryle i sho	ē				1 X Yes 2 No
	28a-1	Director	Maryland Baltimore	10f. Zip Code	10a, Citi	zen of What Country?
	th with 23a or		1 Hamill Court, Unit 58	21210	109.0	U.S.A.
36	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Medical Eventing must be natified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 X No Specify:</li> </ol>	Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
9	"natural", or		15 Decedent's Education 16a, De	cedent's Usual Occupation	16b. Kii	nd of Business/Industry
215	S. nin 72 Su "nin Mediu	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of work . DO NOT use retired)	ing	
21	d with	E C	12 Ho	me Maker	Ot	wn Home
nd	tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden	Ĺ
Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours in the filed within 72 hours in the filed and Mental Hyglene. Int: If item 27 is marked other than "natural", in or other traumatic event, the Medical Evanting or other traumatic event, the Medical Evanting or other traumatic event, the Medical Evantic event events event	ဥ	Joseph Huber  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	Ceci		Unknown
	od 2 s lith ar 27 is rtrau			Coachmans Way, Par		
ē,	s 1 ar f Hea ftem (					cation - City or Town, State
9	Pages ent o nt: If i		I Suburiar 2 Defermation 3 Defermoval from State 1		3-2009 Bal	timore, Maryland
altimore,	+ E E E -		21. Signature of uneral Service Licensee			the second secon
ă	permi Depa Impo any Ir		Dailaia Kuide	1050 York Road, To	owson, Mary	Funeral Home, Inc. land 21204
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		is cardiac or respiratory arrest, Approximate Interval Between Onset and Death	
	ש .≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
W	ecute and trans	Examine	that initiated events c.			
8760,	ficate be executed physician and s the burial-transit	al E)	Due to (or as a consequence of):			
687	ficate phys s the	edical	d			
O. Box	requires that the death certifi seen signed by the attending I nould be defached for use as	Physician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ď.	s that med b		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
ord	w require s been sig should b	ed t	Cerebrosascillar d Jease, emph	ysemA,	1 ☐ Yes 2[	□ No 3 □ Probably 4 ☑ Unknown
Division of Vital Records,		Completed by	Dementia, Cornery artic	j'direkt.	24a. Was an autopsy performed? 1 □Yes 2 XNo	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vita	Physician: r this certific ral director, I	Be (	25. Was case referred to medical examiner?		h (Check only one)	7
of	Physical this call direction	၉	1			6 Other (Specify) WOSPILE
'n	ding l	io	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injur		28d. Describe how injur	/occurred
is:	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm,		28f Location (Street an	d Number or Rural Route Number,
<u>S</u>	al or A after Dire	Certification; To	4 Homicide determined building, etc. (Specify)	,	City or Town, State	
l	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
1	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, Day, Year)
			▶ Afranco	1) 58303	Aus	ust 12 2009
			30. Name and address of person who completed cause of death (Item 23a) (Typ	D 58303 e, Print) 701 10 Charles	-	A Q
			AARON 7 CHYLUES MS (C	101 N Charles	10001	)/v /*· [-
	Sta Registr		31. Date filed (Month, Day, Year) 7 2009 32. Registrar's Signature AUG 17 2009	parke		
				<u> </u>		

Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 109PM **Physician** Ihomas 08 Hugust 90% /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-01-2003 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours Maryland 1 XM 2 F 218-67-8241 5 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County show at 1 Yes 2 No r 28a-f sh notified a Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö ms 23a o must be 21043 United States 7899 Rockburn Drive Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No items 11. Marital Status Black, White, etc. Examiner 1 Yes 3 Pages 1 and 2 should be filed within 72 hours after tx xNever Married 2 ☐ Married 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify Specify: White ò 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Child N A event, th 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be rich and Mental F. Lisa Mary Collins Clint Wallace Sliker ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health ? 7899 Rockburn Drive, Ellicott City, MD 21043 Lisa M. Sliker - Mother : If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. St. Marys Cemetery 08-15-09 Ellicott City, MD 5 Other (Specify) 4 Donatio 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signat MMP., Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorr 1000 Physician disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** 611sma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) g physician and as the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical attending 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Live birth in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2. No 3 Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury this 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 27. Manner of Death Certification: After Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Shand Carolyn Vessica back 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 195 per FH 8894 8/1//09 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 6 Certificate of Death Reg. No. 1. Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 5:00 G.M rrea regory /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 0+11001 Social Security Number oita If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Yrs **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Event instruction to confind 1XYes 2 No MD Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry ndary (0-12) College (1-4or 5+) <u>viron</u>menta Father's Name (First, Middle Be Pages 1 and 2 should be and Mental tou Ston Hural Route Number, City or Town, 19b. Mailing Address (Street and Number or State, Zip Code Informant's Name/Relationship ₩ 22193 Woodbridge of Health arpon Department of Health Important; If item 27 any injury or other troone. 27 Brother Konnie 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Baltimore, 3 Removal from State 8.20.09 21. Signature of Funeral Service License 5151 Balto. Pille Balto. and 23a. Part1. Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cascrious al Immediate Cause (Final to de Physician year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last physician and Due to (or as a consequence of): トピットソーンナストダーナ Division of Vital Records, P.O. Box 68760, Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Day in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown n signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2 No After this certificate funeral director, pag 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 29a. Certifier LECErtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (3a) (Type, Print) March Clisice Lane 30. Name and address of pers ywho completed cause of death (Item 23a) (Type, Print) 720 nnie leea Registrar's Signature 31. Date filed (Month, Day, Year) State 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year August **Physician** 1 homas 15,209 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle 755 c HIMOVE rough If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Mary la wel 6. Sex 1)X M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 226-76-2504 60 Months Days Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinar must be notified at 1 ☐ Hos 2 ☐ No Maryland Funeral Director NIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Stree 1710 East 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONG Ö 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ALVIN L-WILLIAMS - 2. P355 Fred WI Hrs Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Disease Physician End-Stage RESTRICTIVE LUNG /Medical Due to (or and consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tra Records, P.O. Box 68760,3 Due to (or as a consequence of) physician Physician/Medical aftending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy for Month Year Day 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performe page, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00057465 MSKAJAPALIRM.D AUGUST 17, 2009 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200, Reisterstown, MP. 2 1136

State Registrar N.S. Kajapakse MO

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

25 Mainsty Suite

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	ryland	•	rtment of F tificate of				giene Reg. No	200	9 2	5   13
		φ.	1. Decedent's Name	(First, Middle, Last,						2.	Date of De	ath	v Voo		of Death
	Physicia /Medic		Irvin T	. Thompso	on					A	MQU	27 12	200	9 4:	15AM
	Examin		4a. Facility Name (If	not institution, give	~ 5			4b. City Town, o	1	P .		46	County of De	eath .	-0
and I				-nari		NV		La	tov.	er 24 Hrs.   8	11e	1	Dar 1-	FIMO.	
	Funeral		5. Social Security Nu	1 1	<	(In yrs. las 85	t birthday) . Yrs.	If Under 1 Year Months Days	Hours	Min. T.	Date of Bir (Month, Da an 24	in ay, <i>Year)</i> 19:	2/1 1/20	Birthplace ( <i>St</i> a Country)	
	Director		579-22- Usual Residence of D	-5134		03						, 13.	24  Wa:	shingto	II DC
	land ow			10b. County		10c. City,	Town or Loc	ation						10d. Inside	City Limits
	Mary Ff sh	tor	MD	Baltimore	:	Ca	tonsv	ille						1 □ Y	es 2No
	r 28a	Director	10e. Street and Num	ber				10f. Zip Code				10g. Ci	tizen of What	Country?	
	th with	g je	715 Maid	en Choice	Lane PV6	14		21	228			US	SA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it in invident Everities a nutil to invitite a once.	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☒ Widowed 4	d 2 Married	12. Was Decedent E Armed Forces? 1 ∑Yes 2 ☐ N If Yes, Give Year or Dates:		1	Vas Decedent of I fYes, specify Cub ☐Yes 2 No	Hispanic ( an, Mexic Speci		fy Yes or No can, etc.)	)-	14. Race - Ai Black, Wl Specify:	merican Indian hite, etc. white	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)									ss/Industry	unk					
121	vithin sne. han "	Completed	Elementary/Secon	dary (0-12)	College (1-4or 5-	+)		00 NOT use retire inter	d)						
	Hygie Hygie ther t		17. Father's Name (F	First Middle Last)	-		11	Incer	18. Mo	ther's Name (F	First. Middle	. Maider	n Surname)		
Maryland	d be f ental l ed of	Be c	·	orris Tho	mpson					race Ma			,		
7	should bd Me mark matik	ပ္	19a. Informant's Nar	me/Relationship (Tr	roe. Print)	- 1	19b. Mailin	g Address (Street	l t and Nun	nber or Rural F	Route Numb	er, City	or Town, State	e, Zip Code)	
	nd 2 salth ag			Thompson/				Safe Ha						032	
Baltimore,	Pages 1 and 2: ent of Health a nt: If item 27 is y or other trau		20a. Method of Dispo		Removal from State	20b. Plac		sition (Name of natory or other pla		Dat				or Town, State	
Baltir	permit. F Departm Importar any injur		21. Signature			ector		Name and Address			655 W	Ва	1timore	e Stree	t
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	/Medical		disease or condition resulting in death)		Due to (or as a			3000	- 1	(01)				30	74.2
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38760,	physi the t	edical			d										
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sio	tend leath tor: / the fi	cati	2 Accident 3 Suicide	investigation 6 Could not be	on Bloom of India				Yes 2		4 Leastinn	/C44 -		- Pural Pauta	l mbor
Division of Vital Records,	after death after death Director: d in by the f	Certification:	4  Homicide	determined	28e. Place of Inju- building, etc	c. (Specify)	e, iarm, str	eet, lactory, office		20	City or To			r Rural Route i	vumber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Ce			rsician: To the best iner: On the basis o and manner sta	f examination									se(s)
	To the vithin To the complete of the complete	Me	29b. Signature and t	title of certifier				29c. Licen	se numbe	er		29d. D	ate signed (M	onth, Day, Yea	r)
	)		> N/V	FS NU	M. en			Do	+76	900		Aw	fang	11,20	109
			30 Name and addre	ess of person who c	ompleted cause of d	eath (Item 2	(Type,	()	Olco	Land	Bo	11.3	Yaran	4D 21	228
	Sta Registr		31. Date filed (Month	h, Day, Year)	32. Registr	ar's Signatu		barked	. J/C	C-WW C	7	21 1 71	1914		
				nou - · L	YUY MY										

Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Doris Tazewell 5, 2009 9:20 PM M August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Future Care Sandtown Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 1 □ M 2 🗓 F Months Days Hours Min. 215-22-5409 82 Dec 23, 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1√2 Yes 2 □ No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2628 E. Monument Street 21205 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black 3 →Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 custodian city of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Plager Ethel Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Price/daughter 110 N. Central Avenue #102 Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signatu of Euneral Serv Ronald 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate of use (Final Approximate Interval Between Onset and Death 2 HEIME disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse mence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

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d other than "natural", or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Items 23a any Injury or other traumatic event, Ite Mudical Examinations.

Saltimore, Maryland 21215-0036

with the Maryland

Examil Physician/Medical þ Completed

requires that the death certificate be executed

Hospital or Attending

Division of Vital Records, P.O. Box 68760,

and burial-tran physician the attending for use as signed by the a peen cate has t page 2 sl certificate Be Certification: To this After thi death. ithin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu

17PERTENSIVE	CARDIOVASCIALAR	DISEASE

25. Was case refer examiner?	red to medical	26. Place of Death (Check only one)								
1 Yes 2	ίNο	Hospital: 1 ☐ Inpatient 2 ☐	ospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)							
27. Manner of Deat 1 Natural 2 □ Accident	5 Pending investigation		28b. Time of Injury		lc. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe how injury occurred			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fa	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one)	1⊠ Certifying Ph 2☐ Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occ ation and/or investig	urred a gation,	at the time, o in my opinio	ate and place n, death occu	e, and due to the cause(s) and manner as stated.  Irred at the time, date and place, and due to the cause(s)			

(Check only	У	2∟	] IV	ledic	al I
29b. Signature	and	title	of	certi	fier

D 5059107

08-06-2009

DRIVE REISTERSTOWN MD 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

CENTER O BUNNESS 32. Registrar's Signature

State Registrar

Medical

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		partment ( <i>ertificate</i>				lene Reg. No 20	09	26143
	Physicia		1. Decedent's Name (First, Middle, La Elizabeth Ann				-		Date of Dea Month	th Day	Year	3. Time of Death $5.14 \text{ a }_{M}$
	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)		1	wn, or Location	on of Death	agos 1	4c. County		
1	Funeral Director		5. Social Security Number 6. S	Center Sex 7. Age (In yrs. I D M 25 F 8!		y) If Under 1	Year If Und Days Hour	er 24 Hrs.   9	Date of Birtl (Month, Day une 19		9. Birthp Coun	olace (State or Foreign atry) homa
	ъ		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or	Location				, 1,2,		0d. Inside City Limits
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N	death with the Maryland ms 23a or 28a-f show Linust be notified at	<b>Funeral Director</b>	10e. Street and Number 3645 Spring Lane			10f. Zip Co	2064	n		10g. Citizen of US.		try?
156	death	ınera	11. Marital Status	12. Was Decedent Ever in U.	.S. 1	3. Was Deceden If Yes, specify			y Yes or No-		ce - Americ	
-164562 1036	ours after ral", or its Examin	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes 2X					whi	
MR - 16 215-0036	in 72 ho n "natu Audicel	Completed by	15. Decedent's E (Specify only highest gr	ade completed)	16a. De (G life	cedent's Usual C ive kind of work of e. DO NOT use i	Decupation done during m retired)	nost of working		16b. Kind of B	usiness/Ind	dustry
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lisabeth ore, Maryla	und 2 shou alth and M 27 Is mai er traumai		19a. Informant's Name/Relationship Janice Talley/d			ailing Address (S 45 Sprin					, State, Zip 20640	
N, Elisabeth Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 █ Donation 5 ☐ Other (Speci	fy)	Place of Discemetery, of	sposition (Name crematory or othe	of er place)	Date	e	20c. Location	- City or To	wn, State
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	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	juence of):	. ,					1	
60,	rtificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	c Due to (or as a conseq	juence of):							
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σ.	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions	contributing to death but not res	ulting in th	e underlying cau	se given in Pa	art I.	THE PARTY OF			he cause of death?
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Vita	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 12 npatient 2	] ER/Outpa	atient 3 DOA	Othor	lace of Death (		<i>ne)</i> dence 6 □ Ot	her (Speci	fv)
on of	nding Phith. th. After this funeral	tion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Tim Inju	e of 28c	lnjury at Work? 1 ☐ Yes 2		d. Describe h	now injury occu	rred	,,
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		ome, farm, ify)	street, factory, o	office	28	f. Location (S City or Tov		ber or Run	al Route Number,
	Hospita 24 hours Funera tely fille	Medical C		hysician: To the best of my kno miner: On the basis of examina								
	To the within ? To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. l	_icense numb	er 77	6	29d. Date sign	d (Month,	Pay, Year)
		1	Hunt	And course of death (lies	M 232) (Tu	pe, Print)	)'2	060	7	8	11	109
			Grancol	ocompleted cause of death (Item	2 Can	1 00	D.	WAI	Dur	VF.N	ld.	20603
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Fime of Death Physician Month Year THOM 6 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Number . Age (In yrs last birthday) 8. Date of Birth (Month, Day, B. Birthplace (State or Foreign **Funeral** 212-44-960. Usual Residence of Decedent Months Days Hours Min. 1 M 2□ F Yrs. Director Viari death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Exaction or its be notified at 1 Yes 2 No Director nor 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐Yes 2 No δ 3 ☐ Widowed 4 ☐ Divorced ac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) orker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental traumatic ပ 19a. Informant's Name/Relationship (Type. Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1100 Bolton St. 317 Balto, Md. 212 Department of Health a Important: If item 27 Is any Injury or other trau pencer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8 2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ph L. Russ I 110 Md. 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DW 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? cate has t certificate ! Supraventice of Vital 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division ↑ Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 6426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1115-

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August Henderson Vaughan [1] liam 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Prince vattsville Georges Social Security Number Hospital Center Year If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 6. Sex **Funeral** Months Days Hours 64 1 **⊠** M 2 □ F 223-60-2115 December Vivainia Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy prizery or other traumatic event, the Madical Experiment and by notified at once. Hyattsville Prince 1 ☐ Yes 2 ☑ No Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA 20784 Warner Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1965-1967 1 ☐ Yes 2 INo Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tolice Dept Elementary/Secondary (0-12) College (1-4or 5+) Detective 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vaughan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Blackstone 918 Bernicestene Vaughan · Mother Virginia 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Greenview Cemetery Blackstone, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses obert B Bahn Hawkes Funeral Home 504 East St. Blackstone, Va. 23824 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) AUG 1

29a, Certifier

29b. Signature and title of certifier

7

32. Registrar's Signature

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHECKGE MD

3001 HOSPITAL

			Please	Type or Print in						egible.	
			For State	State of Maryla	-	artment of H <i>rtificate of L</i>				2000	20110
			Registrar  1. Decedent's Name (First, Middle, Last	)	- 06	Tuncate of L	Jean I	2. Date of Dea	Reg. No. ath	UUD	3. Time of Death
	Physicia		Maidie Elizabe		on			Month AUGUST	Day	2.009	09:38 A M
Way.	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			ounty of Death	
and .				PITAL		BALTIMO	R E If Under 24 Hrs.	O. D. L. of Divi		N/A	Jaco (Chaha au Faurian
	Funeral Director		219-26-6920	7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da May 30	year) 0, 19	934 N.	place (State or Foreign ntry) Carolina
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits
	Mary If sh	tor	Maryland N/A		Balti	.more					1  Yes 2□No
	3a or 28a	Funeral Director	10e. Street and Number 5009 Pembridge	Avenue		10f. Zip Code 212	15		10g. Citize	en of What Cour USA	ntry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examinar must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 □ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		A. Race - Americ Black, White, of Specify: B1	
Baltimore, Maryland 21215-0036	n 72 hou "natura	Completed	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Occupa kind of work done of DO NOT use retired	luring most of work	ing	16b. Kind	d of Business/Ind	dustry
212	l withii giene. r than	mo	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+)	Driv				Durh	am Bus	Company
pu	e filed al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam			urname)	
yla	ould b Ment sarked satic e	P	John Baggett				Synist				- 0 (1)
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (7) Steve Washingto		19b. Maili	ing Address (Street in Elsrod	and Number or Hui eAvenue	Balti Balti	er, City or more	, Maryl	and 21214
ē,	s 1 an f Heal ftem 2 other		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other plac	α /1 α	Pring		ation - City or To	
e E	Page: nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ga:	rrisor	n Forest	Vet. C	em.			ls, MD
3alti	permit. Departn Importa any injt		21. Signature of Funeral Service Licens		2	2. Name and Addres	s of Facility Ch	atman-	Harr	is Fun	eral Home
	<u></u>		23a. Par 1. Enter the disease, or comp	No.		240 Reis				more, M	Approximate
			nock, or hear failure. List only o	ne cause on each line.				or respiratory a	irrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		infarcti	011				
T	Examiner		Convention list conditions	h	,						
0	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury	Due to (or as a conse	quence of):						
38	executed an and rial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	auence of):					-	
		_		d							
9289	certificate be nding physicia se as the bu	ledic		u	-	N.		-			
O. Box	atter for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у		23	3d. Date of deliv Month	rery Day Year
S, P.	that the polyther the polyther the polyther that the polyther the poly		Part II. Other significant conditions co		sulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to t	the cause of death?
rds	quires en sigr uld be	ed by	ESRD on drale	8 s				1 🗆	Yes 2□	No 3□ Pro	bably 4 Unknown
of Vital Record	e law requires that the do has been signed by the le 2 should be detached	Completed	ESRD on deale Diabetes Hypertensor					24a. Was		24b. Were auto	opsy findings available
= R	ate ⊤ Pag	Com	Hypertension	n					ormed? 2 No	death? 1 ∐Yes	2  No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	<b>~</b>	Oth	26. Place of Dea				
	Phys or this eral dii	۲: 1	1 Yes 2N No 27. Manner of Death	28a. Date of Injury	ER Outpatie	of 28c. Injur	yat ⊔ Nursing H	ome 5 ☐ Res 28d. Describe		Other (Speci	ify)
ion	Attending ir death. ector: Afte by the fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Worl	₹? Yes 2 □No				
Division	l or Atter after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	treet, factory, office			(Street and wn, State)	Number or Rur	ral Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C		ysician: To the best of my k iner: On the basis of exami and manner stated.							
	To the within 2 To the complete	Med	29b. Signature and title of certifier	_		29c. Licens	e number			e signed (Month,	
			Cladlina	· 16		DI	5616		Q	1/13/20	09

2

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHALINI BOYAPATI 2435 West Belvedre Avenue, Boltomore, MD-21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item State of Maryland 100 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	artment of the aith and i ertificate of Death	wental Hyglene  Reg. No. 2009 26147
	Physicia	an	Decedent's Name (First, Middle, Last)     MILDRED	WARD	2. Date of Death Month Day Year AUGUST 4, 2009 1:30 P M
	/Medic		4a. Facility Name (If not institution, give street and number)	4b, City, Town, or Location of Death	
-	Examin	er	FOREST HILL HEALTH & REHAB CENTER	FOREST HILL	HARFORD
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 ■ 0 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	8. Date of Birth Aug. 23, 1918 Mary and Mary and
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation	10d. Inside City Limits
	Mary Firsh	io	Maryland Harford Bel Air		1 □ Yes 2 📈 No
	h the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th wit	al	1303L Scottsdale Drive	21015	USA
980	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examirur must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married   Married  1 Never Married 2 Married 2 Married 2 Married 3 Married 4 Marr	Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 1 No Specify:	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
2-0	72 hou natura	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	16b. Kind of Business/Industry
121	within iene.	Completed	Flementary/Secondary (0-12)   College (1-40r.5+)	e kind of work done during most of worl DO NOT use retired) Me Maker	Own Home
d 2	a filed v al Hygie other t		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)
lan	should be nd Mental marked c	To Be	Harry Kelbaugh	Berth	na Cole
ary	should and Mer Is marke aumatic			ling Address (Street and Number or Ru	ural Route Number, City or Town, State, Zip Code)
ž	s 1 and 2 should by Health and Men item 27 Is marke other traumatic		DiAnne Lockerman / Dtr. 3 Le	xington Road Bel	Air, Md. 21014
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of He Important: If iten any injury or oth once.		1 11 MHuriai 2 Lil Oremation 3 L Hemoval from State 1	ossition (Name of ematory or other place) d Cemetery 8/8/	Date 20c. Location - City or Town, State  /09 Baltimore, Maryland
Balt	permit. Depart Import any inj	y 2		22. Name and Address of Facility Ruck Towson Funera	1050 York Road al Home, Inc. Towson, Md. 2120
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Line or destroying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C	nter the mode of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between Onset and Death
O. Box 68760,	w requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical Ex	d	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
σ.	uires that the signed by detaction	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ ☐ Unknown
Division of Vital Records,	The la ate has page 2	Completed			24a. Was an autopsy performed?  1 \( \text{Yes} \) 2 \( \text{No} \)  24b. Were autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) 2 \( \text{No} \)
Ζ	Physician: r this certific ral director, i	Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpat	Othor	ath (Check only one)  Home 5 Residence 6 □ Other (Specify)
ion of	ling After funer	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation   Pending 2 Accident   Pending 2 Accident   Pending 2 Natural   Pending 2 Natural	of 28c. Injury at	28d. Describe how injury occurred
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	the Hospital or hin 24 hours afte the Funeral Dire mpletely filled in h	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.		
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Drud < D	032299	august 4, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Typ DAVID DUNN - 615 W. MACPHAIL ROAD	e, Print)  - BEL AIR, MD.	21014
ij	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Med	

09-06314 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Eugene Willis, Jr. 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 12, 2009 1449 hrs Medical Examiner Eugene Willis, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Ellicott City 2810 Union Drive If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Days Months Hours Director 217-40-9745 1942 1 X M 2 F July 18. Virginia 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 X No Ellicott City Maryland Howard or 28a-f show hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code the Medical Examiner must be notified at USA 21043 2810 Union Drive Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1 X Yes f Yes, Give Year White 1 Yes 2 X No specify: Specify: 3 X Widowed Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) 2 should be filed within 72 ho h and Mental Hygiene. 27 is marked other than "na Elementary/Secondary (0-12) College (1-4 or 5+ Howard Co. Hospital Doctor MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jane Twigg Eugene Willis, Sr. Be or other traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 3003 Saint Paul Street, Baltimore, MD 21218 John T. Willis Brother permit. Pages 1 and 2 sl
Department of Health ar
Important: If item 27 If item 27 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Columbia Memorial Park 08-18-2009 Columbia, Maryland Donation 5 Other Specify Name and Address of Facility
Witzke Funeral Home, Inc. 21. Signature of Funeral Service License 23a. Part Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED e attending physician for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown med by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 ✔ Probably 4 Unknown Diabetes Mellitus Completed ficate has been s., page 2 should b. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed? death? Yes Yes 2 V No 2 No 26.Place of Death (Check only one director, 25. Was case referred to medica Be Other<sub>4</sub> Hospital: 1 Inpatient ER/Outpatient DOA Nursing Home 5 Residence 6 V Other: Scene this 1 ✓ Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 No neral Director: filled in by the f Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 13, 2009 O.C.M.E. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD Day Year) 32. Registrar's Signature 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, **Physician** /Medical Town or Location of Death ity of Death (If not institution, give street and number) Examiner MINSTE Cente Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. State or Foreign al Security Number (In yrs. last birthday) Year, **Funeral** Months Days Hours Min. 1 □ M 2 🖼 6126 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exprired roust be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 4No Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2□Ko Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Be Jennis ပ 19b. Mailing Address (Street and Number or 19a. Informant's Name/Relationship (Type 06 Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funer Larvice Licensee Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one caus on each line such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final **Physician** B disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Kesh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ♠No 3 Probably 4 Unknown funeral director, page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2**∑N**o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after deatl filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print and address of person MD Registrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2009 Year **Physician** 5 11:40 PM August Margaret Elizabeth Blades /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Envoy Health of Denton Denton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Davs Hours 1 □ M 2 🕅 E Maryland March 6, 1933 Director 220-28-0771 76 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 √Yes 2 □ No Directo Denton Maryland Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21629 Funeral 10819 Greensboro Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by 3

Widowed 4 □ Divorced Caucasian 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) High School Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alverta Rebecca Rogers ဥ Edward Clayton Ouillen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10819 Greensboro Road Denton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) I. Dale Blades
20a. Method of Disposition 21629 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Denton, Maryland 5 Other (Specify) 4 ☐ Donation Denton Cemetery CEMETERY 8/9/2009
22. Name and Address of Facility Funeral Service Licens Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease of shock, or heart failure. RESTRICTIVE CARDIOMYOPATHY Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MYLOIDOS Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Other (specify) signed by the a O 9 Unknown ئە 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ BRILLATION 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page perform 1☐ Yes or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ₽ No ပို funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: 5 □ Pending investigation Injury Division 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified ATTENDING MD

State Registrar 31. Date filed (Month, Day, Year)

AUG U 7 2009

DHMH 17 Rev 1/2001

ddress of person who completed cause of death (Item 23a) (Type, Print)

EINBOLD, MD 321 BLOOMING DAL

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 28 2. Date of Death 3. Time of Death Month 7 **Physician** 08:40 P M Thomas Bullen 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltinou, MD of Maryland Med. Ctr. University If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 □ F Days 325-38-2341 62 1-22-1947 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanties must be notified at Arundel Hanover 1 ■Yes 2 No Funeral Director MD Anne 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or items than "natural", or items 23a 21076 Clark USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: Specify: White Yes Give 5 3 ☐ Widowed 4 ♣ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) WestingLouse Elementary/Secondary (0-12) College (1-4or 5+) Service Tech 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline William Bullen Thomas ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pau Crn. Rd., Hartly, De 19953 Buller 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/30/09 Capitol Crematory Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 615 Bradfordst. TOR BERT FUNERAL CHARL Doser DE 19904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Divertialitis w/ absuss **Physician** resulting in death) /Medical Due to (or as a consequence of 10 d. Examiner perforation Bond Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. ned by the attending physician detached for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by þe End Stage Live Discour, circhosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? Portal rin thrombon's 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Hypertension 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar 29b. Signature and title of certifier

K.T.

To the within 2

29c. License number

P23096

2/20/

29d. Date signed (Month, Day, Year)

7/29/2007

and manner stated.

Bellinon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anus St

December Name   Proc.   Code, (40)   Expert   Code   Cod				1 - For State AMEND PER Registrar	FH #5	FCHD I	Certificate of	Death	nemai riyç F	Reg. No.			
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Physician   Medical   Page   Physician				23a. Part1. Enter the disease, or com- shock, or heart hills.	ncations that naused one cause on each	the math. Don	ot enter the mode of dyi	ng, such as cardiac	or respiratory are	rest,		Approximate	 1
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Company   Comp	Ö	requ been shoul	etec	FACTOR TITT	KINTERITE	9							
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V3  Name and address of person who completed cause of death (Item 23a) (Type, Print)  North Police of Control	Ξ	sicert irecto		examiner?	Hospital:		Oth						
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W3 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ö	s afte	Cert	4 🗀 Hottlicide	building, et	c. (Specify)			City or Town	n, State)			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				> Knowly	· Com	2 Ms	0	31761		7/3/1	200	9	
KB 10+1   Prian M O'Connor M.D. 501 West 7th Street Frederick MD 21701				30. Name and address of person who	completed cause of c	eath (Item 23a) (				- /			
- I DELGH M. V. CUIHEL, M.D., MI WEST /III ALTERIA PREPERTOR. MILL /I/III	KB	10+1		Brian M. O'Conner	M.D 5	01 West	7th_Street	Frederic	k. MD	21701			
State 31. Date filed (Month, Day, Year) 33. Registrar's Signature Registrar AUG 0 3 2009				31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	barked			/ VI			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2009 JULY 9:20 P ILA PAULINE BUTTS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours 1 □ M 2X F Months Days Director 82 JAN 27 1927 NORTH CAROLINA 070-28-0526 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c City Town or Location 10a State 28a-f show "natural", or items 23a or 28a-f show 1 X Yes 2 No Director MD PRINCE GEORGE'S SEA BROOK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7013 STORCH LANE 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: BLACK q 3√ Widowed 4 Divorced Completed traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental F Is marked otl Be BENJAMIN STANLEY KATE **JOYNER** ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st / Health ar BERNARD CLINTON JR./SON 6614 ELKTON TERRACE BRANDYWINE, MARYLAND 20613 permit. Pages 1 and Pepa h ent of Healt Importan: If item 2: any injury or other i other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages ent of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY8/5/2009 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signatur and Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK **Physician** /Medical Due to (or as a consequence of) Examiner ACUTE RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HEPATIC ENCEPHALOPATHY and Due to (or as a consequence of): physician RENAL FAILURE Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy 2 💢 No 1 ☐ Yes 2 🛛 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1₺ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

hours after

Baltimore, Maryland 21215-0036

certificate be executed

Box 68760,

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Records,

of Vital

Division

31. Date filed (Month State Registrar

(Check only

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29b. Signature and title of certifier Chardred Man Kagyet. MD 29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

7-31-2009 MD 52855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7207HANOVER PKY#B. GREENBECT M.D 20770

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryland		rtment of He tificate of D		F	leg. No.	9 26 154
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	3. Time of Death
	Physicia /Medic	al	MOMODU	BANGURA				JULY	27 2009	
,	Examin	_	4a. Facility Name (If not institution, give s			4b. City, Town, or		th	4c. County of	E GEORGE S
			PRINCE GEORGE S  5. Social Security Number 6. Sex	HOSPITAL 7. Age (In yrs. le	ast hirthday)	CHEVER	If Under 24 Hrs	8. Date of Birtl	n	Birthplace (State or Foreign Country)
	Funeral Director			XM 2□F 63	Yrs.	Months Days	Hours Min	. (Month, Da) DEC 20	1945 S	SIERRA LEONE
			Usual Residence of Decedent							10d. Inside City Limits
	nylan show	_	10a. State 10b. County	10c. City	, Town or Lo	cation				1 ☐ Yes 2 ☐ No
	8a-f s	cto	MD PRINCE GE	ORGE'S HYA	ATTSVI	LLE 10f. Zip Code			10g. Citizen of W	/hat Country?
	with th	Pre	10e. Street and Number 3421 55TH AVENUE	# 304		20784			USA	
	death with the Maryland ms 23a or 28a-f show r must be rodiffed at	eral		12. Was Decedent Ever in U.	S. 13. 1	Was Decedent of Hi	spanic Origin? (	Specify Yes or No-	14. Race	- American Indian,
	d within 72 hours after death with the Marylan giene. Than, natural, or ltams 23a or 28a-1 show the Medical Examinat must be notified at	by Funeral Director	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2\( \) No If Yes, Give Year or Dates:		f Yes, specify Cubai 1 ☐ Yes 2 ☐ No	n, Mexican, Pue Specify:	rto Hican, etc.)	Diaci	k, White, etc. BLACK
ş	2 hou		15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occupa	ation during most of we	orking	16b. Kind of Bu	siness/Industry
215-0030	thin 7 8.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired			DDTU	A FILE
V	e filed within 72 h al Hygiene. other then "nate vent, the Medica	5		5+	MAIN	TENANCE	18 Mother's Na	ame (First, Middle,	PRIVA Maiden Sumam	
_	D = D =	To Be	17. Father's Name (First, Middle, Last) PA BAKIE BANGURA				MBALU	KHANU	101	
	n h a		19a. Informant's Name/Relationship (T) KADI BANGURA/WIF		19b. Maili 3421	ng Address (Street a 55TH AVE	NUE #30	Rural Route Number 4 HYATTS\	/ILLE,MA	RYLAND 20784
altimore,	- 7 5 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cre	osition (Name of matory or other plac OAD CEMET		Date 1/2009		City or Town, State
Baltır	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licens		2	2. Name and Address	ss of Facility	J. B. JEI		NERAL HOME AND 20785
			23a. Part 1. Enter the disease or comp	lications that caused the deat						Approximate Interval Between
}	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	FATAL CAR	DIAC A					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq CANCER OF		томасн				
		<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq		TOTACII				
	orted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o`	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
760	nysicia he bu	cal	(	d	<del></del>					
89 3	eath certifica attending ph for use as th	Med	IF FEMALE:						Old Dat	to of dollarons
Box	ath cer uttendin or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	il death 3	☐Ectopic pregnancy ☐ Other (specify)	1			te of delivery inth Day Year
0	that the death ed by the atte detached for	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	1 <del>0</del> a(ii 5)	Other (specify)				
۵.	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions co	ontributing to death but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use cont	ribute to the cause of death?
ds,	uires l signe							1 🗆	Yes 2□No	3 ☐ Probably 4 ☐Unknown
Record	w requir	Completed						24a. Was		Were autopsy findings available prior to completion of cause of
	The lavate has	E O						perfe	ormed?	death? y 1 ☐ Yes 2 ☐ No
Vital		0	25. Was case referred to medical				26. Place of D	eath (Check only	one	
	g: i§.	To B	examiner? 1 ☐ Yes 2 ☐ No		ER/Outpatie		4 Nursing	Home 5 Res		
n of			27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time Injury	Wo		28d. Describe	how injury occur	red
Sio	Attending r death. ector: Afte by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be		ome form o		Yes 2 □ No	28f. Location	(Street and Numb	ber or Rural Route Number,
Division	F i te	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	treet, factory, office			wn, State)	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Co	29a. Certifier 1 ★ Certifying Ph	ysician: To the best of my kniner: On the basis of examination and manner stated.	owiedge, dea ation and/or i	ith occurred at the ti nvestigation, in my o	me, date and pla opinion, death or	ace, and due to the courred at the time	cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
	thin 2 thin 2 the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)
	7 × × 0		9411111	A1000 :	m	n40	1635		JULY	27 2009
	7		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type					
	1		ETHIOPIA ABEBE M				CGO, MAR	YLAND 20	774	
		ate	31. Date filed (Month, Day, Year)	- 32. Registrar's Sign	ature					
	Regist	trar	AUG 0 4 2009	with P.C. Di	aver					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day **Physician** 24, Kenneth Aubrey Bruce July 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6613 Napoli Road Prince George Camp Springs If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 61 **Director** 577-66-5972 Virginia July 16, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Evantical must be retified an once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1XYes 2 No Director Maryland Prince George Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6613 Napoli Road 20748 <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes ≥ □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 No Specify: ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Correction Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aubrey Bruce ၉ Thelma Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dianne Bruce/ Wife 6613 Napoli Road Camp Springs, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland 20a. Method of Disposition 20c. Location - City or Town, State August 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) 3, 2009 Cheltenham, Md. Cemetery Veterans 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Lisensee 4001 Benning Rd. NE Washington, DC 23a. Part 1. Et ter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) **Physician** Metastatic Esophageal Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, death.

P.0. Records, Division of Vital within 24 hours a To the Funeral [

State

Eunice Shakir 6104 Old Branch Ave. 31. Date filed (Month, Da 3 1 2009 JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and

DHMH 17 Rev 1/2001

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Temple Hills, MD

20748

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month P M 7/28/2009 4:00 Carolyn Gillespy Browning /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collington Episcopal Nursing Home Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours Min 1 □ M 2 🖾 F 89 332-12-2548 12/22/1919 Paris, Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road 20721 Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1939-45 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify. Specify: þ 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Millard Gillespy Maude Garwood 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Harp / Daughter 309 Glen Burn Avenue, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/30/2009 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue RAY Rogens Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate course. Enter the course (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year

**Physician** /Medical **Examiner** 

**Funeral** 

Director

28a-f show

23a

, or

"natural"

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, its. once.

72 hours after

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f sho

Physician: The law requires that the death certificate be executed burialattending physician for use as the buria ned by the sign be has page 2 s certificate director,

Box 68760

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Division of Vital Records,

After

Hospital or Attending death. after death Director: / filled i 24 hours a completely

To the within 2 To the I

State Registrar

31. Date filed (Month, Day,

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atrial fibrillation 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Cerebrovascular disease 1 □Yes 2 🔀 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

D47603

7/29/2009

20721

William DuBoyce, MD, 12158 Central Avenue, Mitchellville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-05763

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Alian Blank		- For State of Maryland / Department of Health and Mental hy - For State Certificate of Death		g. No. 2 A	09 2615
Physician	n/	legistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	n Year	3. Time of Death 0630 hrs
Medical Examin		Alan Thomas Blank 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	July 23, 20	4c. County of Dea	
		Juniata Street & Route 155 Baltimore		Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.	_	h(MM/DD/YYYY) 9. B	ian
Director		216-60-7198 1X M 2 F 58 Yrs. Usual Residence of Decedent	12/05/	1950	:ountry)MaryLand
any	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
is show	힏	MD Harford Havre de Grace	10	g. Citizen of What Co	1 Yes 2 No
the Mary	jrec	10e. Street and Number 10f. Zip Code			unitry :
with the	틸	518 North Adams Street 21078  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.		U.S.A. 14. Race - Ame White, etc.	erican Indian, Black,
or iten	Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year  If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	10	<i>Ihite</i>
irs afte tural", iminer		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	work done	Specify: Vi 16b. Kind of Busines	
6 72 hou an "nai	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti	ired)		
. within giene. her the	티	12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N	Vetero	in
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Vernon Blank Cather	rine		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	ဥ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or I	Rural Route Num		
mand 2 sho lealth and tem 27 is traumati	1	Cheryl L. Blank (Wife) 550 Revolution St., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	Date	20c. Location - City	or Town, State
nore		Burial 2 X Cremation 3 Removal from State crematory or other place)  4 Donation 5 Other Specify: R.A. Ferris & Co. Inc. 08/	/06/2009	West Ches	Ston PA
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 37 is marked other than injury or other traumatic event, the Medical	-	Inature of Funeral Service Licensee 22. Name and Address of Facility	ellman F	uneral Hon	ne, P.A.
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	Street.	Havre de est, shock, or heart	Grace, MD Approximate Interval
/Medical		failure. List only one cause on each one.  Immediate Cause (Final disease a. Multiple drug (Quetiapine) & alcohol			Between Onset and Death
taminer	1	or condition resulting in death)  Due to (or as a consequence of):			
	Jer	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	등	d. 322 27 292 £ 22ME 2205 0/22	/ሰዓ		
60, ate be ex obysician ne burial	Medical	A ON ENDED		23d. Date of deliv	PON
5876 artificat fing ph	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month	Day Year
Sox (death ce attender for use	Physician/	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown g Unknown			
Division of Vital Records, P.O. Box 687 rate of actions: The law requires that the death certific its after death.  al Director: After this certificate has been signed by the attenting to in by the funeral director, page 2 should be detached for use as the control of the state of the control of the state of the control		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
S, P puires th	ed by		1 Ye:		robably 4 V Unknown autopsy findings available
cord	ompleted		autor perfo	osy prior death	to completion of cause of ?
Reference The tificate or, page	C	25. Was case referred to medical 26.Place of Death (Check	1 Yes	2 No 1 🗸	Yes 2 No
Vita Tysician This cer	o Be	evaminer?	ing Home 5	Residence 6 🗸 Of	her: Scene
J of Jing Pt After funeral	삥	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending 1 7 (23 (00) 1 1 1 Yes 2 X No	28d, Describe subject	now injury occurred ingested	quetiapine &
ision Attend er death. rector: by the f	icati	2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	alcoho 28f. Location (	1 Street and Number or	Rural Route Number, City
Div pital or ours after erat Di	Certification:	Suicide 6 Could not be determined (Specify) other	Perryv	State) Juanita ille, MD	Rural Route Number, City St & Rt 155
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cau at the time, date	se(s) and manner as s and place, and due to	stated. the cause(s)
To T	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed (	
		MUL ( ) O.C.M.E.		July 24, 2009	
		30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	/ID 21201		
Sta	ate	31. Date filed (Month, Day Year) /32. Registrar's Signature			
Regist	rar	AUG 17 2009 Jenera B. gracker			

DHMH 17 Rev 1/2001 OCME 2006

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	-	<ul><li>State Registrar</li></ul>					Ce	rtifica	te of l	Death			Reg. No.	20	119	26	158
Dhuniai		1. Decedent's Name										<ol><li>Date of Dea Month</li></ol>	ath Day	usa ter	Year	3. Time o	
Physicia /Medic	al	Charle		L.		own						July 2		2009			)5 a <sup>M</sup>
Examin	er	4a. Facility Name (li 315 Whi			eet and numb	er)			Salis	_				Wic	of Death	0	
Funeral Director		5. Social Security No. 210–18–8	3883	6. Sex 1 🔀 N	7.	Age (In yrs.	last birthday Yrs.	Month:	er 1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Dat 08/14/	h y, Year) 1925		9. Birth Cou Penr	place (State intry) nsylva	or Foreign nia
and		Usual Residence of 10a. State	10b. County	,		10c. Ci	ity, Town or L	ocation								10d. Inside C	City Limits
Maryl -f sho	jo	Maryland	Wico	omico		5	Salisbu	iry								1 🔀 Yes	s 2□No
with the	Director	10e. Street and Nur						10f. Z	ip Code	)1				zen of V JSA	What Cou	intry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be indiffed at once.	by Funeral	11. Marital Status 1 □ Never Marri	ied 2 Mar	12.	Was Decede Armed Force 1 XYes 2 If Yes, Give	es? □ No				lispanic Or an, Mexica Specify		ecify Yes or No- Rican, etc.)			ck, White,	ican Indian, etc. white	
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f Heal		20a, Method of Disp				20b.	Place of Disp cemetery, cre	osition (N	ame of	20)		Date	20c. Lo	cation -	City or T	own, State	
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permit. Departm Importa any inju		21. Signature of Fu			3/						eral Rd.	Home Pr	ofes	sio	nal D 21	Associ 804	ation
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Hospita 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one)	1 ☐ Certifyi 2 ☐ Medica	ing Physic I Examine	cian: To the base and manner	sis of examin	nowledge, de nation and/or	ath occurr investigat	ed at the t	ime, date a	and place eath occur	and due to the	cause(s date and	and m	nanner as , and due	s stated. to the cause	e(s)
<b>Го the</b> vithin Г <b>о the</b> юпрі	Me	29b. Signature and	title of certific	er				2	29c. Licens	se number	,		29d. Da	te signe	ed (Month	h, Day, Year)	
		•	vihr						1)4	709	4		7	/30	109		
13 EN		30. Name and addr	ress of person	who com	pleted cause	of death (Ite	em 23a) (Type	Print)	510N	sne	1	57-L15	BUR	7 1	1)2	1804	
Sta Registr		31. Date filed (Mon	ath, Day, Year	032	32. Re	girtrar's Sigr	nature	de	N.			54 L15		,			

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			State Amend Items 23	tate of Maryland / [ art1, b, 23 per	Department of H Repartment of H Certificate of L	ealth and M 3709dhb Death	ental Hygien	e 10. 2000	00150
	Physici /Medic		1. Decodent's Name (First, Middle, Last)	anes	Banks		2. Date of Death Month 07 27	2009	3. Time of Death J
	Examin		4a. Facility Name (If not institution, give stre			Location of Death	4	c. County of Death	•
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	place (State or Foreign httry)
	th the Maryland or 28a-f show	Director	Usual Residence of Decedent  10a. State  10b. County  5005  10e. Street and Number	10c. City, Tow	n or Location		"	Citizen of What Cour	0d. Inside City Limits  1  Ses 2  No  ntry?
-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Exacility in unst be invitified at	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No ff Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 22 No	specify:	ocify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla Kind of Business/In-	etc.
Maryland 21215-0036	d be filed within 72 ental Hygiene. ked other than "ne ic event, Ire Media	To Be Completed	(Specify only highest grade co	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired Studia		(First, Middle, Maide	thod di Charlen Surname) Ranks	stri e
altimore, Maryl	Pages 1 and 2 should nent of Health and Mer int: If Item 27 Is marke iry or other traumatic	F	19a. Informant's Name/Relationship (Type.  20a. Method of Disposition  1 Surial 2 Cremation 3 Rem	dauh 20b. Place 20b. Place come to	Mailing Address (Street and Disposition (Name of py, prematory or other place)	-Rd. La	urel, De	y or Town, State, Zip	
Baltin	permit, Pages Department of Important: If It any injury or once.	V 13	21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  23. Part 1. Enter the disease, or complicat	Cephodaions that caused the death. Do	22. I me and Address 308 N	ss Facility YCU	ng + Mc/ Seaton or respiratory arrest,	hason fe	Approximate Interval Between
S S S S S S S S S S S S S S S S S S S	Physician /Medical Examiner	ıer	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)  a. a. 5540tially list condition if any, leading to immediate	Due to (or as a consequence	) collecen	95 4 rec	tu ulce	rs 7	Onset and Death
松子	ficate be executed physician and s the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):	TIFICATION AFFROVE	O BY MEDICAL EXAMINE	ER .	
30+∏ :0. Box (	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c.  23b. Was decedent pregnant in the past 12 months?  1 □Yes 2 □No 9 □ Unknown	If yes, outcome of pregnancy  1  Live birth 2 Fetal death 4  Pregnant at time of death 9  Unknown	h 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
₩ Drids, P	w requires that been signed to should be deta		Part II. Other significant conditions contrib	outing to death but not resulting i	in the underlying cause given	en in Part I.	23e. Did tobacc	o use contribute to t	
/ital Reco	s <b>ician;</b> The law requ certificate has been rector, page 2 shoulc	Be Completed by	25. Was case referred to medical examiner?	,	lou.		24a. Was an autopsy performed 1 □Yes 2 (Check only one)	prior to co	opsy findings available mpletion of cause of
并 Division of Vital Records	To the Hospital or Attending Physician; The Is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation investigation	pital: Inpatient 2 □ ER/O 28a. Date of Injury (Month, Day, Year) 28b. 28e. Place of Injury - At home, fa building, etc. (Specify)	Time of lnjury M 1	y at k? Yes 2 □ No	me 5 ☐ Residence 28d. Describe how in 28f. Location (Street City or Town, St	njury occurred  and Number or Rur	
(6	n 24 hours n 24 hours ne Funera pletely fille	Medical (	29a. Certifier (Check only one)	ian: To the best of my knowledg r: On the basis of examination a and manner stated.	e, death occurred at the ti nd/or investigation, in my o	me, date and place, opinion, death occur	and due to the caus- red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the complex c	M	29b. Signature and title of certifier (	US UD	29c. Licens	e number	8 <sup>29d.</sup>	Date signed (Month,	Day, Year)
	Sta	ate.	Daild C. Censo 31. Date filed (Month, Day, Year)	M V CSO7  82. Registrar's Signature	Deer 10.	nte Dr.	Scelishe	y MD	21809
	Regist		AUG 13 2009	Senera D. a	barres				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** August 9 7:30  $A^{M}$ Elizebeth Mae Brinegar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital Elkton 8. Date of Birth (Month, Day, August If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 1 F 1945 Maryland 63 219-44-5869 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1ÆTYes 2□No Director MD Cecil Perryville 10g. Citizen of What Country? 10e Street and Number 10f Zip Code ō 23 Collins Drive 21903 U.S.A. 23a Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify Specify: White à 3 ₩Widowed 4 Divorced i and Mental Hygiene. Is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry iled within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Mamie Kegley Louis Cox ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Betty J. Druyor (Daughter) 23 Collins Drive, Perryville, MD 21903 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 8/14/09 Bel Air Mem. Gdns. Bel Air, Maryland Name and Address of Facility
Tarring-Cargo Funeral Home, P. Aberdeen. Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse wence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy The performe certificate 1 □Yes 2 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔑 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. the

State Registrar

2

29b. Signature and

31. Date filed (Month, Day, Year)

AUG

ne and address of person who completed cause of death (Item 23a) (Type,

32. Registrar's Signature

Maryland 21215-0036

timore.

Box 68760.

P.0.

Records,

Division of Vital

DHMH 17 Rev 1/2001

29d. Date signed Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician**  $\mathsf{A}^\mathsf{M}$ 2009 5:55 McIntosh August 6 Lucy Butler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fairhaven Sykesville Carroll 8. Date of Birth (Month, Day, July 2, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours 1 ☐ M 2 🗷 F 216-28-6216 1913 Virginia Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County la or 28a-f show t be notified at show 1 ☐ Yes 2 ☑ No Director MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 U.S.A. ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Department of Health and Mental Hygiene.
Important: If item Z7 is marked other than "natural", or items any injury or other traumatic event, tre Modical Examiner many place. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ⋧ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Randolph McIntosh Lucy Latham Risdon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Chapman (Niece) 6004 Chapman Road, Mason Neck, VA 22079 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/09/09 Moser Crematory Warrenton, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moser Funeral Home Inc. 20186 233 Broadview Ave. Warrenton, VA23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 norexia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lementia Celars Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed itallaten 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 🕅 No 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1- Natural death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760. Division of Vital Records, Hospital or Attending Physician: The 24 hours after death within 2

Certification: To 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 1am

Rd Eldersburg MD 21784

State Registra

31. Date filed (Month, Day,

32. Registra/s Signature

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2009 31 Harold A. Cardoza Ju1y 5:20p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 836 Fairoak Avenue Hvattsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye. 9/30/1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 1 X M 2 □ F 579-07-5459 86 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Prince George's Hyattsville 1XYes 2 No Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [ 836 Fairoak Avenue 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No 1942—
If Yes, Give
Year or Dates: 1943 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiene. 27 is marked other than "r r traumatic event, ne Med Federal Communications College (1-4or 5+) Elementary/Secondary (0-12) Offset Printer Commissions 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Cardoza Louise Harrison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 836 Fairoak Avenue, Hyattsville, MD other Esther O. Cardoza - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important; If ite any Injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 8/7/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature Funeral Service 3401 Bladensburg Rd., Brentwood, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that daus shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) mon /Medical (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physiclan: The law requires that the death certificate be executed after death. attending physician and for use as the burial-tran P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1∐Yes 2ℤNo been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' this certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural nours after death.

neral Director: Aft

y filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier MD August 3,2009 D64583 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRUPAM A D. MITIKIRI MD Ro Hyatterille 20782 Registrar

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / De	epartment of Ho Certificate of D			0000	20162
			Registrar  1. Decedent's Name (First, Middle, Last)	Jeruncale or L	reall i	2. Date of Death	g. No.	3. Time of Death
	Physicia		Sadie Louise Collins			July 29	Day Year 2009	1:35 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Deat	
			Southern Maryland Hospital	1211 1 237	nton If Under 24 Hrs.	O Date of Birth		George
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 10,	Year) 1921 9. Birt	hplace (State or Foreign untry) aryland
	0		Usual Residence of Decedent					
	show dat	5	10a. State 10b. County 10c. City, Town of					10d. Inside City Limits 1   Yes 2   No
	the M 28a-f potifie	Director	DC  10e. Street and Number	Washingto	on	10	g. Citizen of What Co	untry?
:	3a or	iO IE	1616 Marion Street NW # 019		20001		United S	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His if Yes, specify Cubar	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
00	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene, and the Trian and Trian	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 🛣 No If Yes, Give Year or Dates:	1 □Yes 2X No	Specify:		Specify: B1	_
3	z hour		15. Decedent's Education 16a. D	Decedent's Usual Occupa	tion		6b. Kind of Business/	Industry
7 10	thin //	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done di ife. DO NOT use retired)		ng		
7	led wi lygier her th		12th	Housew	ife 18. Mother's Name	/First Middle M	Priv	ate
ב פ	of be the serial Hard control of the	Be	17. Father's Name (First, Middle, Last)  John Contee			Sarah Ly]	,	
3	should and Me mark umatid	ဍ	19a. Informant's Name/Relationship (Type. Print) 19b. N	Mailing Address (Street a				Zip Code)
ž :	s 1 and 2 soft Health a item 27 is other trau			907 Kipling				
ນ ວ	ges 1: tof He Fiten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of crematory or other place		ust	0c. Location - City or	
Dallillion	rtmen rtant: njury			ny Memorial  22. Name and Address	5, 2		andover, M neral Home	
0	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other Once.		21. Signature of Funeral Service Dicensee		ning Rd.		nington, D	
			23a. Part Enter the discusse, in complications that caused the death. Do no shock, in heart failure. List only one cause on each line.	t enter the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
۰. F	hysician		Immediate Cause (Final disease or condition	PA	Ann			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	A CONTRACTOR	al In	( 1 -		
		e.	Soquer trally list conditions, if any leading to immediate  Due to (or as a consequence of	130001010	31 TLA	tacho	0	
	cured od ansit	Examine	Squeritally list or office if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ension				
, 00	icate be executed physician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of	):				
0	icate be executed physician and s the burial-transit	edical	d					
מא מ	attending p		IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of de	livery
֓֞֞֞֜֞֜֞֜֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	e dearr	Physician/M	in the past 12 months?  1 □ Yes 2 □ No  2 □ Helden to death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
ב ב	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause give	n in Part I	23e Did tob	acco use contribute to	the cause of death?
cords,	signe d be d	d by	FAIT II. Office Significant Conditions Continuumly to death but not resulting in C	ne underlying cause give	ir iir r arci.			robably 4 Onknown
S	s beer shoul	Completed				24a. Was an	24b. Were au	utopsy findings available
ב ב	ine ia ate ha: age 2	J Wo			****	autopsy perform 1 □ Yes 2	ed? death?	completion of cause of 2 □ No
<u>.</u>	ertifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of Deat			
5 6	this c	မ	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		4 LI Nursing Ho		nce 6 Other (Spe	ecify)
200	After	tion		ury   Work	? ? ∕es 2□No	28d. Describe how	w injury occurred	
2	Atten	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
5	ral or rs afte al Dir led in	Cert	Dunding, etc. (opeany)			City of Town,	Otaloy	
	nospi 24 hou Funer stely fil	Medical	29a. Certifier (Check only one) Check only one					
:	To the hospital or <b>Attending Prysician</b> : The law requires that the deam certifue 24 hours after dead.  Within 24 hours after dead.  After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Mec	29b. Signature and title of certifier	29c. License	number	29	d. Date signed (Moni	th, Day, Year)
<b>,</b>	> - > - 0		· SIOn.MO	D (	0062057		7/29/	2009
0	4		30. Name and address of person who completed cause of death (Item 23a) (T					
-	- 1		Sandra Banks M.D. 7503 Surratts Ro	oad Clinton	n, Maryla	nd 2073	5	
	Sta Registr		31 2009 A seek	1				

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Catlett Robert AUGUST 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner A11egany 9. Birthplace (Sta Country) MD Memorial Hospital Cumberland Date of Birth (Month, Day, Year) Jul 8, 1941 7. Age (In yrs. last birthday) (State or Foreign 5. Social Security Number Funeral 1 → M 2 □ F Months Days Hours Min. 218-38-2396 68 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD Allegany Cumberland 1 ☐Yes 2 ☐ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 11824 Amherst Avenue USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify. Specify: þ 3 Nidowed 4 Divorced white "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Allegany Co. Roads Dept. Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Catlett Jane Shipley ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

141 Buckfalls Road Bedford PA 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 15522 Gary Dawson son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 8/15/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Lio-22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure set only one cause on each line. Immediate Caus- (Final disease or condition resulting in death) Physician BRAINSTEM ZWEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation thin 24 hours after death.

the Funeral Director: Aff
empletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier lam tum M 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, CUMBERIAND WILLIAM m.D. MEMORIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 20

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** AUG.9,2009 HAROLD ROGER COOKSEY 4:05 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12495 CHARLES STREET LA PLATA CHARLES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Months Days Hours Min 220-28-5555 83 Yrs. Director 8-17-1925 MD. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Natical Examinar must by mother an MD. Director CHARLES LA PLATA 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12495 CHARLES STREET 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No

1 ↑ Yes Give U.D. MILIT

13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican Miles Company C Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evantina once. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 δ. Specify:WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMER/STORE OWNER SELF EMPLOYED 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM ELMER COOKSEY AMY LEE COOKSEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA C.FEENEY-DAUGHTER P.O.BOX 1022 LA PLATA, MD. 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITX EPIS.CH.CEM.8-12-09 4 ☐ Donation 5 ☐ Other (Specify) NEWPORT, MD. M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 Mul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death ulae Immediate Cause (Final **Physician** ON disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the SS IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 D No certificate 1 ☐ Yes 1 □Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Dea 28b. Time of 28d. Describe how injury occurred

funeral ( 124 hours after death.

le Funeral Director: Af

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only 29b. Signature and title of certifier

31. Date filed (Month, Day,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**ORIGINAL** 

AUG

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur

State

Medical

0 Year) 32. Registrar's Signature

within 24 hor To the Fune completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2 Date of Death 3. Time of Death 1. Degedent's Name (First, Middle, Last) **Physician** 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Maryland INTOIN Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 18-92-9690 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner is ust be notified at 1 Des 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Experiment, until burn once. JUNIAP 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Blac <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be uvelle ames huesda 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Pnint) UNICIP Street Temple Hills WD 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State Wendale Riverdate Cremotory: 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility 21. Signature of F neral Service Licensee 710 Home intendi ampsprings MD 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Atherosclerofic Cardio voscular disess **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an autopsy performed? Yes 2 140 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of conflict 253200

State Registrar 30. Name and address of person w

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Surratts Rd

impleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2005 9 3:33 Aug. AM LEE ROY DeBOARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) 1/4/1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min. 295-12-0724 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director Street MD. Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21154 United States items 23a 2054 Mt. Horeb Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Ye ar or Dates: WW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2XNo Specify. White Specify: Completed by WW II 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States al Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) General Maintenance Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Health and Mental em 27 is marked o Wiley DeBoard Sarah Kathryn Porter Calvin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn V. DeBoard (Wife) 2054 Mt. Horeb Rd. Street, MD. 21154 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other ODICE. Baltimore. 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 DOther (Specify) Cremation 8/14/2009 Hampstead, Maryland Carroll 21. Signature of Fune al Savice kicensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral blacken Jarrettsvillel, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that cally dithe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 days **Physician** STROKE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner obstructive Pulmonary Pixare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Dav 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 After this certificate 1 □ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) the funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Momicide Hospital 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifie H0067817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dive, Bel Air, MD awareak

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State Registrar 31. Date filed (Month, Day,

Year)

AUG

32. Registran's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Dorothy Mae Everett 2009 4:35 July 29 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Denton Caroline Caroline Home for Hospice If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Min 80 229-20-9438 1 ☐ M 2 🔀 F North Carolina Jan. 6, **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show adieal Evaminar must be notified at 1 ☐ Yes 2 🗓 No Preston Director MD. Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21655 4118 Poplar Neck Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. 1 ∐Yes 2 ∰ If Yes, Give Year or Dates: 2 📆 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry سم withir عدم Mental Hygiene. رe SZ Is marked other than "n r traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) Nursing Certified Nursing Aide 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eddie Sutton Roy Sutton ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richmond, VA 23222 405 Fayett Ave., Geneva Everett/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or conce 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastern Sh. Veterans 108/03/09 Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** 060 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine **al or Attending Physician:** The law requires that the death certificate be executed after death. Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy 5 ☐ Other (specify) P.0. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 17028,CE Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation illed in by the f 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Melinda Year)
31. Date filed (Month, Day, Year)

32. Registrar's Signature

136

JUL 30 2009

700

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Lednum

00023922

Preston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month  $\mathtt{P}^{\mathtt{M}}$ GERTRUDE L. ELMENDORF Ju<sub>1</sub>y 31, 2009 11:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland, Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, Year) Feb. 25, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2√□ F Feb. Director 125-26-3345 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2☐No Director Maryland Frederick Frederick 10e, Street and Number 10f Zip Code 10g. Citizen of What Country? 7407 Willow Road 21702 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14 Race - American Indian. 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: ò Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Teacher Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Clara C. Unknown Carl A. Schutt ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6402 Crane Terrace, Bethesda, Maryland 20817 Douglas W. Elmendorf / permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 8/3/09 Smithsburg, Maryland 4 Donation 5 Dother (Specify) ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enjer the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mohoma disease or condition resulting in death) /Medical Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ∐ Yes 2 ∐ No 3 ∐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 1 ☐ Yes 2 🗷 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed As hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and elety filled in by the funeral director, page 2 should be detached for use as the burlat-transit P.O. Box 68760, Division of Vital Records, To the Hosp within 24 hou To the Funel completely fil

with the Maryland

death v

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

KB

Registrar DHMH 17 Rev 1/2001

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) 4ubric State

4 Homicide

29a, Certifier

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of cerifier

agy

and manner stated.

Registrar's Signature

MO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0055061

29d. Date signed (Month, Day, Year)

### Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 3:07 p English Corbett Freeman July 29 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospice Dove House 8. Date of Birth (Month, Day, Nov 11, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🔯 M 2 🗆 F 1923 Director 85 Pennsylvania 183-12-6629 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examiner must be notified at 1X Yes 2 □ No Funeral Director Taneytown Carroll Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21787 USA 123 Morning Frost St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? \*\*EXX'es 2 \\_No 1943 If Yes, Give Year or Dates: 1946 Black, White, etc. s 1 and 2 should be filed within 72 hours after c of Health and Mental Hygiene. Item 27 is marked other theme. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sears and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shipping/Receiving 10 Assistant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Imelda Smith ဥ Grover English, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Taneytown, MD Helen E. English 123 Morning Frost St. Pages 1 ament of H Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2009 Eldersburg, Maryland Lakeview Mem. Park 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Lices 412 Washington Rd., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** MONY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify). P.0. 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Speci 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending 1 ☐Yes 2 ☐No investigation Director: filled in by the 3 Suicide 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

CENTER ST

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

within 24 hours after To the Funeral Dire To the WJL 5tIVA 4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR CAFEAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Medical

Registrar DHMH 17 Rev 1/2001

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WESTMINSTER, MD 2-115

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Day Physician JULI UNE /Medical . City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner LAPLATA MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Days 1 □ M 2 💢 F 235-38-0480 83 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 1 ☐ Yes 2 📉 o Director 10g. Citizen of What Country? 10e. Street and Number Funeral AMES MADISON . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROCESSOR U.S. 18. Mother's Name (First, Middle, Maiden Surname Maryland 17. Father's Name (First, Middle, Last) Be Rose AWRENCE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) 22401 Edgell DR. Frederick TWINL Kenneth Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -3-09 Fredericksburg, VA Mercer Cremator 8 11089 James Madison Phy 21. Signature of Funeral Service Licenses C 03 22. Name and Address of Ficility Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner Vere and burial-trar certificate be exect Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknov þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contribut Division of Vital Records, þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b autopsy performed? Yes 2 No 2**4**No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Hbb 0.5 H 31. Date filed (Month, Day, Year)

AUG 0 4 2009

32. Registrar's Signature

			For State Registrar	State	of Mary		artment of F rtificate of		and Me		gien Reg. No	2000	26	172
	Dhusisi		1. Decedent's Name (First, Middl	e, Last)					2.	Date of De Month	ath Da	ay Year	3. Time	of Death
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	Examin	er	4a. Facility Name (If not institution		umber)		4b. City, Town, o		of Death		40	c. County of Death		
-st			28 E1k Chase I	rive 6. Sex	7 Age (In	yrs. last birthday)	E1ktor		24 Hrs.   8	Date of Bir	th	Cecil 9. Birth	place (State	or Foreign
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	hin 72 hours after death with the Maryland e. e. "natural", or items 23a or 28a-f show Madical Evaning rust be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever	in U.S. 13.	Was Decedent of H	lispanic Ori	igin? (Specif	y Yes or No		14. Race - Amer	ican Indian,	
٥	or ite		1 ☐ Never Married 2 ☐ Mar	ied Armed F 1 □Yes If Yes, G	2 📉 No		If Yes, specify Cuba 1 □Yes 2ሺ No	an, Mexicar Specify:		can, etc.)		Black, White		
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Mar	2 sho and is ma	j X	19a. Informant's Name/Relations			- 1	ng Address (Street						ip Code)	
رب ≥	and tealth m 27 her tr		James A. Eder/	Son			S. Tartar					21921		
baltimore,	iges 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		n State		sition (Name of natory or other plac	j 41	Date Lugust	12,		_ocation - City or T		
	nit. Pa artme ortant injury		4 ☐ Donation 5 ☐ Other (S 21. Signature, of Funeral Service			Elkton C	emetery  2. Name and Addre		2009	-		Elkton,	MD	
n D	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Pulleral Service	W. A.	11 mm		icks Home 03 W. Sto	e for	Funer	als,	P.A.	on MD 3	1921	
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~ F	Physician		shock, of heart failure. List Immediate Cause (Final disease or condition	only one cause on	each line.	Store (	ard.		/to				Unka Unka	l Death
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5	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pre	gnant at time known	e of death 5[	Other (specify) _					WOITH	Duy	1041
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cords,	urres n sign ld be	d by		_			,			1 🗆 '	Yes 2	2 □ No 3 □ Pro	bably 4 🗜	Unknown
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	After After funera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	g (Mo.	e of Injury enth, Day, Yea	ar) 28b. Time o Injury	Wor	ryat k?  Yes 2.∐		d. Describe	how inju	ury occurred		
VISION	death ctor: y the	ficat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	and he	e of Injury -	At home, farm, str		Yes ZL		Location (	Street	and Number or Ru	ml Route Nu	ımber.
<u> </u>	after after Direction by	Certification:	4 ☐ Homicide determ	inea build	ding, etc. (S	At home, farm, str pecify)	out, lactory, office			City or To	wn, Sta	te)	ar riodio rio	,,,,,,
	To the Hospital of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifyln (Check only 2 Medical	ng Physician: To the	ne best of my	y knowledge, deat	h occurred at the ti	me, date ar	nd place, an	d due to the	cause	(s) and manner as	stated.	(a)
	in 24 the Fu	Medical	one)	Examiner: On the and ma	nner stated.	imination and/or ir			ath occurred	at the time,				
i	Zor With	Σ	29b. Signature and title of certile	0.00	C 41	. D	29c. Licens	0.	10		29d. D	ate signed (Month		
			, ek	relider.		- )		8332	<b>ζ</b> Δ			8/11/09		
			30. Name and address of person $S$ . $S$ Sach	/ - 2		(Item 23a) (Type, 26A E	tach St	. E	2ktm	MO	2/	1921		
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's S		0 1 01	,	-2470					
	Registr	ar	ALIC 1	7 2000	163	h	1							

> DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U S Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<sup>Day</sup> 4:17 P M William Allison Fidler 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Atlantic General Hospital Berlin Worcester If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/7/1925 Birthplace (State or Foreign Country) f Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 219-10-4966 83 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2X ☐ No Collier Naples 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1400 Blue Point Ave, Unit 202 34102 USA 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Kellogg Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William A. Fidler Lillian Northern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Melicent Fidler / wife 1400 Blue Point Ave., Unit 202, Naples, FL 34102 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/30/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fund of Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intertho Due to (or as a consequence of): Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 📉 No 1 ☐ Yes 2 🗷 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Flural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner Col 1/2/1925 1291 Ö しつる /೧ 49೬७ on of Vital Records, FIDIRY Division S - S

burial-tran attending physician as the t filled in by the funeral director, After this To the Hospital or Attend within 24 hours after death To the Funeral Director:

Physician/Medical

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

**Physician** 

**Examiner** 

**Funeral** 

Director

LISTRIBUTE OF THE THEN "NATURAL", OF ITEMS 23a OF 28a-f Show traumatic event, If a Modical Examination must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item.

Physician

3altimore, Maryland 21215-0036

/Medical

Director

Funeral

ģ

Completed

FL

DH 15+1

State Registrar

29b. Signature and title of certifier

29c. License number

10064120

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the date and place in the date and place in the date and place in the date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and begoess of person who completed cause of death (Item 23a) (Type, Print)

zerchan. (Month, Day, Year) AUG 0 3 2009

and manner stated

		For State Registrar	Please			and / De	partment of Hertificate of	lealth and	Men	tal Hygi	ene- U	109	26!74
Physici	an	1. Decedent's Name (Fi	irst, Middle, La	st)	ET EMO	HED	JR.			Month 25		Yeer	3. Time of Death 7:50P M
/Medic Examin	cal	MELVIN  4a. Fecility Name (# not PRINCE GEOF	_		FLETC	nek	4b. City, Town, or				4c. Coun	ty of Death E GEO	
Funeral Director		5. Social Security Numb 212-68-0554	per 6. S		7. Age ( <i>ln yi</i>	rs. last birthd	Months Davs	If Under 24 Hi		Date of Birth Month, Day,	354	9. Birthr WASH	INGTON, DC
Maryland -f show	tor		cedent b. County RINCE G	EORGE		City, Town o	r Location					1	10d. Inside City Limits 1 ☐Yes 2 ☐ No
th with the 23e or 28e at be not	Funeral Director	10e. Street and Number 5105 CHURCH					10f. Zip Code 20720			10	g. Citizen o U .	f What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Say injury or other traumatic event, the Medical Examinating the notified at Examinating the motified at Examinating the motified at Examinating the solution.	þ	11. Marital Status 1 ☑ Never Married 3 ☐ Widowed 4 ☐		12. Was Dece Armed Fo 1 Ves It res, Giv Year or D	rces? 2 No	U.S.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify erto Rica	Yes or No- in, etc.)		ace - Americack, White, eify: BL	
d within 72 ho giene. r than "netur ine Medical	Completed			ducation ade completed) College (1	-4or 5+)	(G	ecedent's Usual Occup live kind of work done le. DO NOT use retired ORER	during most of w	vorking		6b. Kind of		dustry
ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First MELVIN M.						18. Mother's N MARY RE	EED				
and 2 sho balth and 27 Is m er traum		19a. Informant's Name				510.	ailing Address (Street  5 CHURCH RI	D BOWIE,	, MD	20720			
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Departi Departi Importu any inje		21. Signature of Eunera	M Service Cice	1500			22. Name and Addre						íE
Physician /Medical Examiner  popularitansit	cal Examiner	23a. Part1. Enter the d shock, or heart fal immediate Cause (Findisease or condition resulting in death)  Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injust that initiated events resulting in death) Last	ilure. List only al ions, diate	a. Due to	aused the deadch line.  AL  (or as a cons)	CAX sequence of):	EDIAC.		-		st,		Approximate Interval Between Onset and Death
The law requires that the death certificate is the has been signed by the attending physionage? Should be detached for use as the transmissions.	Physician/Medic	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1  Yes 2 No 9 Unknown	nths?		ointh 2 ∐ Fo nant at time o	etal death	3 Ectopic pregnancy	1				Date of deliv	ery Day Year
w requires that been signed b should be deta	by	Part II. Other significer	nt conditions	contributing to d	eath but not r	resulting in th	e underlying cause giv	ren in Part I.	_		acco use co		the cause of death?
sician: The law re certificate has bee irector, page 2 sho	Completed								-	24a. Was an autops perform	y	o. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of 2 No
sician certifi rector	o Be	25. Was case referred examiner? 1 ☐ Yes 2 No	to medical	Hospital:	Inpatient 2	<b>X</b> ER/Outpa	atient 3 DOA Oth	26. Place of D		heck only one 5 ☐ Reside		What (Sagai	6.1
To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certifical completely filled in by the funeral director.	Certification: To	27. Manner of Death  1 Natural 5 2 Accident	Pending investigatio	28a. Date (Mon	of Injury th, Day Yeer,	28b. Tim Inju	e of y 28c. Injur		28d.	Describe ho	w injury occ	urred	al Route Number,
pitel or Al ours after o erel Direc		4  Homicide	determined	build	ng, etc. (Spe	ecify)	, street, factory, office	me, date and nia		City or Town	, State)		
the Hos thin 24 ho the Fun mpletely i	Medical	(Check only 2 one)  29b. Signature and title	Medical Exe	niner: On the b	asis of exam	ination and/o	or investigation, in my o	pinion, death oc	ccurred a	at the time, da	ate and plac	e, and due t	to the cause(s)
F 3 F 8		) In	mark		A	26	263	3688			_		
3		Name and address ARIFFIN	of person who	completed caus	se of death (I	tem 23a) (Ty	100 Print)	DR	CH	EVER	LY M	1 2	0785
Sta Registr		31. Date filed (Month, C AUG 0 4 2	2009	132. F	tegistrar's 6ig	ture sails	/				•		

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	State of Maryland / Department of Health and Mental Hygiene O 🔾 💆	1

			State of Maryland State of Maryland Registrar		artment of H rtificate of		,	Reg. No.	
	Physici /Medio		1. Decedent's Name (First, Middle, Last) William Ricardo	Fau	ılcon		July 27,		3. Time of Death 11:27 A M
	Examir		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, o		ath	4c. County of De Prince G	eorge's
	Funeral Director	5	5. Social Security Number  6. Sex 1	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		9. E 1940 Wa	Birthplace (State or Foreign Country) shington, DC
	show show	-i	Usual Residence of Decedent  10a. State 10b. County 10c. City, T  Maryland Prince George's Clir		cation				10d. Inside City Limits 1 □ Yes 2 No
	with the N s of 28a-f	Direct	10e. Street and Number		10f. Zip Code 2073	85		10g. Citizen of What	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or itema 23a or 28a-f show aumatic event, tra Medical Exerction minat be routiled at	by Funeral Director	8500 Mike Shapiro Drive #229  11. Marital Status  1 \textbf{X} Never Married 2 \to Married Married 3 \to Widowed 4 \to Divorced Divorced Pear or Dates: Vietnam				(Specify Yes or No- erto Rican, etc.)		merican Indian,
Maryland 21215-0036	id within 72 ho giene. er then "natur , tre Medicel I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12	(Give	dent's Usual Occup kind of work done DO NOT use retired Technician	during most of v d)	vorking	16b. Kind of Busine Verizon	ss/Industry
/land	uld be file Mental Hy irked oth	To Be (	17. Father's Name (First, Middle, Last)  William R. Faulcon Sr.			18. Mother's N	lame (First, Middle, UNKNOWN	Maiden Sumame)	
	1 and 2 should Health and Mer Iem 27 is marke		19a. Informant's Name/Relationship (Type, Print) Lawrence D. Bland / Executor		-			or, City or Town, State nton, Marylan	
altimore,	T of		I Double 2 Comment 3 Dremoval nom State	e of Dispos etery, crem as Crer	sition (Name of natory or other place TATOTY	сө) 08/	Date 01/2009	20c. Location - City  Edgewat	or Town, State er, Maryland
Balt	permit. Pag Department Important: eny injury o		21. Signature of Figural Septide Licensee		. Name and Addre		George P. Oxon Hill,	Kalas Funera Maryland 2	1 Home P.A. 20735
感	Physician		23a. Part / Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		er the mode of dyin	,	iac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequent		Anter		)iscore	2	
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	42	Pena	Dia	eole		
8760,	rate be executed thysician and the burial-transit	cal	bue to (or as a consequent		بنعادت				
.O. Box 68	at the death certifical by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)	у		23d. Date of Month	delivery Day Year
٩.	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting	ig in the ur	nderlying cause giv	ven in Part I.			to the cause of death?  Probably 4 Wunknown
al Records,		Completed					24a. Was autop perfor 1 \( \text{Yes} \)	sy prior t	autopsy findings available o completion of cause of ? es 2 \( \text{No} \)
r Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referrer to medical examiner?  1 ☐ Yes 2 (No Hospital: 1 ☐ Inpatient 2 VER	/Outpatien	t_3 DOA Oth	er	eath <i>(Check only on</i> Home 5 Resid	ne) lence 6 □Other (S	pecify)
ion of	ding h. After fune		27. Man - r of Death  1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	b. Time of Injury	Wor	y at rk? Yes 2 □ No	28d. Describe h	ow injury occurred	
DIVISION	a afte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	he Hospital or in 24 hours afte he Funeral Dirk pletely filled in t	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tirvestigation, in my o	me, date and pla opinion, death oc	ice, and due to the courred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To the To the Complete	Σ	29b. Signature and title of certifier		29c. Licens	50 number 04 15 87		29d. Date signed (Mo	200 <sup>3</sup>
r	10+1		30. Name and address person who completed cause of death (Item 23 Scott Kelso MD 7503 Surratts Road		Print)				
	Sta Registr	27 20	31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUL 3 1 2009  August D. Factor	2	, ram yici				W

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death August 1, Day 2009 Year **Physician** 5:30 A M Robert Howard Gross /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 8. Date of Birth (Month, Day, Year) Dec 6, 1966 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**∑**M 2□F Months Hours Maryland Dec 6, 220-56-2621 42 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 X No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 USA 805 Charles James Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Cynthia Ann Roth Edward M. Gross ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s D partment of Health ar Important: If item 27 is any injury or other trau Edward M. Gross/father 907 S. Caroline Street Baltimore, MD 21231 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Final Journey Crematory 08/03/09 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. BOx 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the Jease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 106 UNRNOW disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my onless, death Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 174/955

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print) Codar lane Columbia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month. **Physician** 2125 2009 il 25, SHERMAN GRIFFIN JR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9000 Browsord Laurel Prince If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, SEPT. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. 1☐M 2☐F 67 WASHINGTON, DC Director 579-54-9847 18 1941 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 1 XYes 2 No PRINCE GEORGE'S LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā USA 9000 BRIAR CROFT LANE # 304 20708 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🛣 No Specify: 2 3 ☐ Widowed 4 ☑ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH SECURITY PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SHERMAN JOSEPH GRIFFIN SR. CARRIE E. HALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12117 STONEY BOTTOM ROAD GERMANTOWN, MARYLAND 20874 CHARLES GRIFFIN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 【\*Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 7/31/2009 RIVERDALE, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ebrovas enan Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the buriat-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be VASCU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1₽ Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** 7:30 JULY John B. Gray 30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SINAL HOSPITAL OF BALTIMORE CITY BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours MOM 2 F 83 Director Sept 05 1925 PA 199-16-4844 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 □No Director Pikesville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7018 Alden Road USA 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Systems Analyst SSA 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any linjury or other traumatic evone. Elizabeth Noble မ Elmer Hoyt Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Granleigh Road Owings Mills, MD Diane Edman/daughter 20a. Method of Disposition 20c. Location - City or Town, State 08/04/2009 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIL **Physician** SHOCK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNEUMOTHORAX 1 Yes 2 No 3 Probably 4 Unknown Completed CORDNARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe END STAGE CHRONIC OBSTRUCTIVE FULMONARY DISEASE 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician After this ours after death. To the Hospital within 24 hours a To the Funeral I

Registrar DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Cajerigneli M. B. B.S.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave., Baltimore, MD 21215 RAJEEV GUPTA, MBBS; SINAI HOSPITAL OF BALTIMORE

RES-000

29d. Date signed (Month, Day, Year)

JULY, 30, 2009

and manner stated.

32. Redistrar's Signature

Leneur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Malcolm G. Heggie /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner S 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 9 1925 **Funeral** Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Months Days 1 XM 2 □ F Hours Min. Director 034-12-5996 84 MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exercipes must be notified at Director 1 ☐ Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 14 Hingham Lane Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. XYes 2 □ No 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1943-1946 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry altimore, Maryland 21215 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnes." Elementary/Secondary (0-12) College (1-4or 5+) 12 Special Agent FBI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Heggie Bessie E. Brown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Heggie, Wife 14 Hingham Lane, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 8/3/2009 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home of Funeral Service Licensee 108 William Street, Berlin, MD 23a. Part v Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4₩ Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 25 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 ₩ Hospital: Other: 4 \sum Nursing Home After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) HOSPICIZ funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death. leral Director; A filled in by the fu 2 No 1 ☐ Yes 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASTI

Registrar

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31. Date filed (Month, Day, Year)

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AUG 0 3 2009

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32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:48 PM 2009 Margaret C. Hunt August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Rising Sun 447 Post Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 23 9. Birthplace (State or Foreign Country) 1927 Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year! Days 1 □ M 2 🗓 F **Director** 179-26-6785 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at Director 1 ☐ Yes 2 X No Maryland Ceci1 Rising Sun death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21911 United States 447 Post Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harley Clifford Alice Heron ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Starboard Ct., Perryville, MD 21903 Janice Gibson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☑Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 8,2009 Port Deposit, Maryland Hopewell Cemetery 21. Signature of uneral Service Lic 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 echaro 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease condition resulting in death) **Physician** un pour y Lung /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 9 Unknown معرض nas been signed ا page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 1 ☐ Yes 2 ☑ No 1 □Yes 2 DN6 After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check onl one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation I Director: A 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 □ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Thomicide To the Hospital o within 24 hours aff To the Funeral Di 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8.4.2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S 126 A, E 31. Date filed (Month, Day, 32. Registrar's Signature State AUG 0 4 2009 Registrar

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last) William Hale  2. Date of Death July 30 ( 4b. City, Town, or Location of Death Woodside Center  Silver Spring	
/Medical Examiner Surj 30 (  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	
Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	,2009 Year 7:00 PM
Woodside Center Silver Spring	4c. County of Death
	Montgomery
Funeral Director  5. Social Security Number 227-38-9007  Usual Residence of Decedent  6. Sex 7. Age (In yrs. last birthday) 78  78  7. Age (In yrs. last birthday) 78  78  78  79  70  70  70  70  71  70  70  70  70  70	Year) 1930 <sup>9. Birthplace (State or Foreigr</sup> Country) 14, Bedford Ct.,VA
	10d. Inside City Limits
District of Columbia Washington	¥XXyes 2 □ No
106. Street end Number 106. Zip Code 106. Zip Code 106. Zip Code Ur.	g. Citizen of What Country?
10a. State   10b. County   10c. City, Town or Location   Washington   10c. Street and Number	14. Race - American Indian, Black, White, etc.  Specify: Black
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	6b. Kind of Business/Industry
Elementary/Secondary (0-12)  College (1-4or 5+)  Florist	T1 C1
Twelth One FIOTISC  18. Mother's Name (First, Middle, Last)	Flower Shoppe
The state of the s	,
The part of the pa	City or Town, State, Zip Code)
20a. Method of Disposition    Solution   State   Solution   State   Solution   State   Solution   S	Oc. Location - City or Town, State
4 Donation 5 Other (Specify)  Holcomb Cemetery  7,2009 Ly  21. Signature of Funeral Service Leading Robert G. M	nchburg, Virginia
Daniel W. Harrison	ngton DC 20020
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errespiratory errespiratory.  Physician  [Medical]  Immediate Ceuse (Final)	st, Approximate Interval Between Onset and Death
disease or condition resulting in death)  Coronary Artery Disease  Due to (or as a consequence of):	
eu la companya de la	
The contribution of the co	
And the matter of the matter o	
O of the state of	acco use contribute to the ceuse of deeth?
O of the base of t	2 □ No 3 □ Probably 🏋 ☑ Unknown
© # Peripheral Vascular Disease, Diabetes	
Dementia  24a. Was en a performe  24a. Was en a performe  25. Was case referred to medical examiner?  1   Yes  25. Was case referred to medical examiner?  1   Yes  25. Was case referred to medical examiner?  1   Yes  25. Was case referred to medical examiner?  1   Yes  26. Place of Death (Check only one)  1   Yes  27. Manner of Death  1   Manuar of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  Month?  Work?  Month?  28c. Injury at Work?  Work?  Month?  28d. Describe how determined  28d. Describe how determined	autopsy ad?  24b. Were autopsy findings available prior to completion of cause of death?
To the second of	2 <sup>N</sup> No 1 □ Yes 2N No
25. Was case referred to medical examiner?	
26. Place of Death (Check only one)  Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence  27. Manner of Death 28d. Describe how	ce 6 ☐ Other (Specify)
27. Manner of Death 1	injury occurred
O B S O S O S O S O S O S O S O S O S O	
28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify)  28f. Location (Street City or Town, Street)	et end Number or Rural Route Number, State)
	se(s) and manner as stated. a and place, and due to the cause(s)
Use the control of t	
The state of the part of the pasts of the pa	I. Date signed (Month, Day, Yeer)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Certifier (Check only one)	I. Date signed (Month, Day, Yeer)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number	

DHMH 16 Rev 6/95

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		1- For State Crivial yield / Departing	eate of Death	Reg. I	No. 2009 261
Physicia	in/	1. Decedent's Name (First, Middle,Last)  Jean O. Harris		Date of Death     Month Da	ay Year 1805 hrs
Medical Exami	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 27, 2009	4c. County of Death
( )		3114 Varnum Street	Mount Rainier		Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bin 2/49-38-7/453 1. No. 2/49-38-7/453 6. Sex 7. Age (In yrs. last bin 2/49-38-7/453 1. No. 2/49-38-7/	thday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	<b>-</b>	MM/DD/YYYY) 9. Birthplace (State or Foreign
Birector		249-38-7453   1 M 2XF   85	Yrs.	July 7,	1924 Country) SC
v any	ı	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
daryland 28a-f show d at once.	į	Maryland Prince George 10e. Street and Number	Mt. Rainier	10a	1 X Yes 2 No Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once	Director	3114 Varnum Street	20712		United States
n with the ms 23a be not		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Sport of the Specific Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
r death or ite	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	1 Yes 2 X No specify:	rican, etc.)	Specify: Black
urs afte tural",		3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of		6b. Kind of Business/Industry
6 172 hor nn "na cal Ex	letec	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti		D ! !-
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed by	12th  17. Father's Name (First, Middle, Last)	Laundry Technici	an e (First, Middle, Mair	Private
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Rufus Harris		Lula Hop	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho r tranmatic event, the Medical Examiner must be notified at once.	٥	19a. Informant's Name/Relationship (Type, Print )  Douglas Parks/ Nephew	b. Mailing Address (Street and Number or 12414 Rochino Cour		
imore, MD 2 Pages 1 and 2 shou ment of Health and N ant: If item 27 is n or other tranmatic		20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,	Date 2	Oc. Location - City or Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  Me	ntory or other place) Harmony emorial Park 3	July 31, 2009 1	Landover, Maryland
Saltil ermit epartm nporta ijury o	1	21. Signature of Fu eral Service Lick nse			neral Home, Inc.
Physician	-	23. Part I. Enter the disease, or complications that caused the death. Do n	4001 Benning Rd. Not enter the mode of dying, such as cardiac	NE Washing or respiratory arrest,	ngton, DC 20019 , shock, or heart Approximate Interval
/Medical	10	Immediate Cause (Final disease a. Intracerebellar Hemorrhage			Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):  b. Hypertensive Cardiovascula			
	Je.	if any, leading to immediate  Due to (or as a consequence of):	ii Diocase		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (c. Due to (or as a consequence of):			
ecuted and - transii		d		···	
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy	<del> </del>		23d. Date of delivery
Box 68760, edeath certificate be the attending physic of for use as the but		23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn.	ancy	Month Day Year
Box 687 e death certific the attending	Physician/	1 Yes 2 ✓ No 9 Unknown 9 Unknown	5 Other (Specify)		
P.O. BOX s that the deatl gned by the att	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.		acco use contribute to the cause of death?
ords, P.C w requires that is been signed should be dete	ted t			24a. Was an	2 No 3 Probably 4 V Unknown  24b. Were autopsy findings available
COrc	Completed			autopsy performe	prior to completion of cause of death?
tal Rec cian: The l certificate !		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director. After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	To Be	Tes 2 No			esidence 6 🗸 Other: Scene
n of viding Phy. h After tl		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b.	. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how	N Injury occurred
ivisior for Attendath after death Director:	ficat	2 Accident Investigation 28e. Place of Injury - At home.	farm, street, factory, office building, etc.		eet and Number or Rural Route Number, City
Div Hospital o 24 hours afi Funeral D	Certification:	4 Homicide determined (Specify)		or Town, Stat	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one)  2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, an investigation, in my opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To the within To the comple	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		D_n_n	O.C.M.E.		July 28, 2009
R		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examine		MD 21201	
St	ate		Jes J		··-
Regist	rar	31. Date floor Age 2009 Service 32. Registrary signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:50 p July 29, 2009 Hartline Eleanor Estella /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Finksburg 4515 Sun Berry Dr. 9. Birthplace (State or Foreign Country)
Mary Land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours Min. 1 □ M 2 □XF 95 July 28, 1914 Director 213-10-7277 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exp., increment be mained as 1 ☐ Yes 2 No Director Maryland Carroll Finksburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 **USA** Funeral 4515 Sun Berry Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ★No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: Specify. ģ Specify: White 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene.

7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Margaret Marie Kelly George William Pistel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 21048 Finksburg, MD 4515 Sun Berry Dr. Ruth Scheiner \_Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Ridge Mem. Park 8/3/2009 | Elkridge, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 21. Signature of Funeral Service Licens 412 Washington Rd. Westminster, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CAN BSC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 | Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 200 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown peen s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy 1 □Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 1 Residence 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28c. Injury at Work? 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physicia on the best of maknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Example. On the basis of example investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only To the within 2. one) and manner state 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

5

State Registrar 30. Name and add ass of person

JUL 31

Item 23a) (Type, Print)

cause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2009 Anna Marie Hershey 1:05 p M July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Reisterstown 3 Mamopa Court If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 214-22-0953 82 Oct 17, Maryland Director 1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, it a Montal Examination to context and another traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore Reisterstown 1 ☐Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 3 Mamopa Court USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Completed by 1 ☐Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Elementary/Secondary (0-12) College (1-4or 5+) Government Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosemary "unknown" Harry Shultz ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Mamopa Court, Reisterstown, MD 21136 Marlene E. Brady, sister 20b. Place of Disposition (Name of South 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/30/2009 Winfield, MD Carroll Crematory Myers-Durboraw Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Livensee 91 Willis Street, Westminster, MD 21157 tou 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest since, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arcmorea **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 2 No 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1'K Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 □Could not be 3 ☐ Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Baltimore, Maryland 21215-0036

WJZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 300 Pikesville MD 4000 old Court KTOODNICK State

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Medical

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name: Theodore Hopewell

	1	For State Registrar	ype or Pri id. Item 2 State of M	ai yiai i				Death		Reg. No	Z. [] [] []	2618
Physician	-	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	eath Day		3. Time of Death
/Medical		Theodore R.	Hopewe		Sr.				JULY	6	200	
Examiner	ľ	la. Facility Name (If not institution, give s	treet and number)	)				Location of Deal	h I	4c.	County of Dea	
		Milford Manor  5. Social Security Number 6. Sex	7. Ac	ae (In vrs.	last birthday)		cesvi. er 1 Year		8. Date of Bi	rth	Baltim 9. Bi	ore rthplace (State or Forei country)
uneral irector	- 1		M 2□F	99	Yrs.	Month	Days	Hours Min.		ay, Year)		country) dysville, N
		Usual Residence of Decedent		,		1			, idea .		. J I OILCO	
thow Tal	- 1	10a. State 10b. County			y, Town or Lo							10d. Inside City Limit
Ba-f-	2	MD Baltimo	re	P1	kesvil				<del></del> -			1 ☐ Yes <b>2</b> (☐ N
or 2 Dire		10e. Street and Number					ip Code				izen of What C	Country?
s 23a	2	4204 Old Milford		E	0 140		1208		S4 - V N	US	14. Race - Am	oden Indian
if item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at or other traumatic event, the Madical Examinar must be notified at To Be Completed by Funeral Director	Dy ruite	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	I2. Was Decedent Armed Forces' 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?				ispanic Origin? (\$ an, Mexican, Puer Specify:	to Rican, etc.)	0-	Black, Wh	
atura cal E	2	15. Decedent's Edu	ation		16a. Dece	dent's Us	ual Occup	ation		16b. K	ind of Business	s/industry
ner then "natura it, its Madical E	2	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+1	(Give	kind of y DO NOT	vork done use retired	during most of wo	rking			
Te marked other then " reaumatic event, the Max	5		1		custo	dia	1			Mac	hine C	0.
event Be	20	17. Father's Name (First, Middle, Last)							me (First, Middle		Sumame)	
To atte	2	George H. Hopewe	11		· · · · · · · · · · · · · · · · · · ·			Laura	J. Hebro	on		
E E	ĺ,	19a. Informant's Name/Relationship (Ty		<b>.</b>				and Number or R				
m 27 her tu	- 1	heodore Russell Ho	pewell,		-			th Rd.	Pikesvil			1208
Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Place of Dispo semetery, cres se Hill	matory o	r other plac	y Ju1	y 10,200		ocation - City o Iagerst	
Importe any inju		21. Signature of Funeral Service License	Dorna						Grove-Bo aynesbo			eral Home, 68
sician and sedical aminer aminer Examiner	CAG	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a1 He	uence of): ematoma uence of):		hri	ve				May 2008
ed by the attending physicic detached for use es the bu	nysicianymedic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	ll death 3	⊒Ectopic ⊒ Other	pregnancy specify)	1			23d. Date of d Month	lelivery Day Year
		Part II. Other significant conditions cor		,	•	inderlying	cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death
should should leted	3	Chronic Ke	nal t	aili	SYR				1 🗆	Yes 2	□No 3□I	Probably 4 Dinkno
hes 9 2	aldino									opsy formed?	prior to death?	
this cartificate al director, pag	บ	25. Was case referred to medical examiner?							ath (Check only	one)		
To This c		1 162 51140			ER/Outpatier			41 Nursing	Home 5 ☐ Res			ecify)
or: After he funera	allon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o Injury	M M	28c. Injur Wor 1 🗆	yat k? Yes 2 □ No	28d. Describe	how inju	ry occurred	
within 24 nous attended to the form to the Funeral Director: After the completely filled in by the funeral Medical Certification: 1	Cer	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ir building, e	njury - At he etc. <i>(Specil</i>	ome, farm, st	reet, fact	ory, office			(Street allown, State		Rural Route Number,
or the Funer impletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the bes ner: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurre vestigati	ed at the tir on, in my o	me, date and place opinion, death occ	e, and due to the turred at the time	e cause(s e, date an	and manner d place, and d	as stated. ue to the cause(s)
	Σ	29b. Signature and title of certifier				4	29c. Licens					nth, Day, Year)
To th						1						
To th Comp		30. Name and address of person who co	ln as	MD death (Iter	n 23a) (Tvoe	Print)	D	51051		J	147	21042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year РМ Leonard Simon Hefter 2009 3:00 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerford Assisted Living Washington County Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Voar 1 XM 2 ☐ F 579-40-8504 84 Director Dec. 8.1924 Pennsvlvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, that we die event, the wedit of the same of 1 □ Yes 2√2 No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 901 Trumpington Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 MYes 2 □ No If Yes, Give 1943 — Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Storage Company is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Jacob Hefter ပ Ophelia Hirshfield Hefter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Brenda Auger-daughter 901 Trumpington Lane Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Smithsburg Crematory 8-4-2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) □Yes 2□No the detached 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performes 1 ∐Yes 2 No 2 🗆 No 1 □ Yes Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□Yes 2XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending hours after death investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one)

State Registrar 29b. Signature and title of certific

Name and address of

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

0/2/

DX

within 2

09

son who completed cause of death (Item 23a) (Type, P

32. Registrar's Signature

MD

29c. License number

D28686

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1330PM 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Celi ELK:ton
If Under 1 Year | If Under 24 Hrs. Hollingsworth
Security Number J 6. Sex. Manor Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Months Days 149-64-3176 Usual Residence of Decedent Yrs. Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Medical Expression must be notified at 1XYes 2 □ No Director ?eci 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2192 Funeral HOL Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married 1 ☐Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLerk Keta 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental hasz 19a. Informant's Name/Relation ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other traugnee. May MD Ella ElKton, ingsworth mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/04/2009 Newark, DE United Gematory Services

22. Name and Address of Fac

Strano and

635 Church permit. 21. Signature of Funeral Service License Feeley Family hurchman's Rd, Newark DE 19702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician a P.O. Box 68760 Physician/Medical attending ph for use as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year in the past 12 months? Month 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 Yes 3 Probably 4 Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 1 No 1 ☐Yes 2 No 1 ☐ Yes or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 2 No 1 ☐ Yes 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attend within 24 hours after death To the Funeral Director... 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ath Name and address of person who completed cause of death (Item 23a) (Type, Print) MI Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	1 - For State Registrar	State of Maryland		rtment of H			giene 2 0 0 9	26183
Physic	ian	Delegate (First, Middle, Last)     Delegate (Pirst, Middle, Last)	L.	JONES			2. Date of Dea Month	th Day Yeer	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give s	ary land Hesp	rital	cli	Location of Death		Prince	George's
Funeral Director		5. Social Security Number 6. Sex 1 Security Number 6. Sex 1 Security Number 1 Securi	7. Age (In yrs. la	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAY 1(	r, Year) C	rthplace (State or Foreign ountry) FLORIDA
Baltimore, Maryland 21215-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 271s marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinal must be notified at		MD PRINCE GE  10e. Street and Number  4013 BYERS STREET  11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  JOSEPH JONES  19a. Informant's Name/Relationship (Ty MAZEL SPENCER/MOT  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature Fanarial Service Licens  23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	ORGE'S  12. Was Decedent Ever in U.S Armed Forces? 1   Yes 2 No If Yes, Give Year or Dates: cation   completed)  College (1-4or 5+)  3 YRS  The Print   YRS  Th	13. V If I I I I I I I I I I I I I I I I I	TOL HEIGH  10f. Zip Code  207  Vas Decedent of HI Yes, specify Cuba  Per's Usual Occup- kind of work done of NOT use retired  ADMINIS  G Address (Street of NORTHWES)  sition (Name of natory or other place)  AME CHURO  Name and Addres  474 LANDO  or the mode of dying code  10f. Norther place  10f. Name and Addres   ispanic Origin? (Sin, Mexican, Puerto Specify: attion attion 18. Mother's Nam MAZEL and Number or Ru ST COUNTY See) CH CEME 8 ss of Facility DVER ROAD	coeffy Yes or No- pecify Yes o	Black, When Specify:  16b. Kind of Busines  PRIV. Maiden Sumame)  R  If JENNING 20c. Location - City of BELLVILLE ENKINS FUNERAL MARYLAN.	EFLORIDA ERALL HOME	
death certificate be executed  Wedica  Examine  e attending physician and  od for use as the burial-transit		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)		ficial.	+ nju	19		
death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  Part II. Other significant conditions co	23c. If yes, outcome of pregnar  1	death 3□ eath 5□	Ectopic pregnancy Other (specify)		23e. Did to	23d. Date of o Month	lelivery Day Year to the cause of death?
COrd w requir	Completed by						24a. Was	an 24b. Were prior to death	Probably 4 Unknown autopsy findings available o completion of cause of es 2 \overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{
Division of Vital Re To the Hospital or Attending Physician: The la within 24 hours after death. To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical example?  1	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)   25   2007   28e. Place of Injury - At hobuilding, etc. (Specify	28b. Time of Injury 1 § 3	28c. Injur Woo 1 — eet, factory, office	ner: 4 Nursing H	28d. Describe I	dence 6 Other (S, how injury occurred of the standard Number or	Toney day
To the Hospital or within 24 hours after To the Funeral Director completely filled in I	edical	(Check only 2. Medical Exam one)	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, deat	n occurred at the til vestigation, in my o	opinion, death occi	e, and due to the urred at the time,	cause(s) and manner date and place, and c	ue to the cause(s)
, ,	×	29b. Signature and title of certifier	flater i	00	29c. Licens		2	July 3/	OS POOF
15		30. Name and address of person who of	rester 3001	Hos	pital.	Drive,	Chev	esty Men	yland
S Regis	tate trar	31. Date filed (Month, Day, Year)  AUG 0 4 2009	32. Registrar's Signa	aver		,		/	•

09-05975 Jarronn Jackson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

arronn Jackson		- For State	f Maryland / Depal <i>Cer</i> i	rtment of tificate of		ng Mental r		eg. No.	200	9 2618
Physicia	1/	egistrar I. Decedent's Name (First, Middle,Last)					2. Date of Dea	ith	Year	3. Time of Death
ledical Examin		JARRONN  4a. Facility Name (if not institution, give s	JACKS		4h City Town	or Location of Dea	Month July 30, 2		County of Death	2150 hrs
		Prince Georges Hospital	sileer and number)		Cheverly	of Education of Boo		Pr	ince George	's
Funeral Director		5. Social Security Number 6. Sex 1 X N	7. Age (In yrs. la	st birthday) Yrs			in. 8. Date of Bi	rth(MM/D	D/YYYY) 9. Birt Foreig 980 Cou	hplace (State of MARYLAND untry)
any	<u> </u>	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Locat	tion			_		10d. Inside City Limits
	۱,	MD PRINCE GE	ORGE'S	UPPER	MARLBOR	RO				1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code			-	en of What Cour	ntry?
1 with the Maryland ms 23a or 28a-f sho be notified at once.		10529 CAMPUS WAY	SOUTH  12. Was Decedent Ever in U.3	C 13 W	207	/4 Hispanic Origin? (	Specify Yes or N		USA 4 Race - Ameri	can Indian, Black,
leath w	a) I	Never Married 2 X Married	Armed Forces?  1 Yes 2 X No	5.   15, <b>v</b>	res, specify Cut	oan, Mexican, Pue	to Rican, etc.)		White, etc.	
s after rral", o	≱⊦	3 Widowed 4 Divorced II  15. Decedent's Education (Specify only	Yes, Give Year or Dates:	160 Decedes	Yes 2 X	No specify: pation (Give kind of	of work done		nd of Business/I	ACK
2 hour "natu	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			life. DO NOT use r				nadou y
5-0036 Iled within 7: Hygiene. J other than			4	PHARMA	CEUTICA	L SALES	(F) 1 3 A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		LIVATE	
e filed val Hyging ed oth	υl	17. Father's Name (First, Middle, Last) DIMETRIUS	ACKSON			18.Mother's Na	me (First, Middle, E CARSO		surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	12 12	19a. Informant's Name/Relationship (Typ. JESSICA JACKSON		19b. Mailin	ng Address (St CAMPUS	treet and Number of WAY SOU	or Rural Route Nu	mber, Cit	y or Town, State LBORO , M	, Zip Code) D 20774
re, N 1 and 2 Health Fitem 3	ł	20a. Method of Disposition  1 Burial 2 X Cremation 3		Place of Dispo crematory or o	sition (Name of ther place)	·	Date	20c. L	ocation - City or	Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify:		VERDAL	E CREMA	1 2	4/2009	RIV	ERDALE,	MARYLAND
Balt permit. Departu Import injury	+	21. Ignature of Fundral Service License	**		Name and Addr	ress of Facility J	. B. JEN			
Physician	1	23a. Part I. Enter the disease, or complice failure. List only one cause on each	cations that caused the death.	Do not enter	the mode of dyi	ng, such as cardia	c or respiratory a	rrest, sho	ck, or heart	Approximate Interval Between Onset and
/Medical xaminer			Iultiple Injuries	f).						Death
		Sequentially list conditions, b	de to (or as a consequence o	···						
	ine	if any, leading to immediate D cause. Enter Underlying Cause	ue to (or as a consequence o	f):						
ted   	Examiner	events resulting in death) Last	ue to (or as a consequence o	f):						
68760, certificate be executed nding physician and use as the burial - transit	Medical	UNPENDED d.	AMENDED							
68760, certificate be rding physici se as the buri	n/Me	23b. Was decedent pregnant in the	23c. If yes, outcome of preg		etal death	3 Ectopic pre	gnancy	230	d. Date of deliver Month	y Day Year
Box 6876 e death certificat the attending phy-	Physician//	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of de		Other (Specify)					
the ched		Part II. Other significant conditions	9 Unknown	esulting in the	underlying cau	se given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
vrequires that the speen signed by should be detact	g b						-			bably 4 Unknown
of Vital Records, g Physician: The law requirements the this certificate has been some a literator, page 2 should	Completed							s an opsy form <u>ed</u> ?		utopsy findings available completion of cause of
	팅	200	<del> </del>		00.0	de a de Constitución de la const	1 V Yes	2 N		es 2 No
Vital ysician: his certi	o Be		ospital: 1 Inpatient 2	ER/Outpatier		Other Nu	rsing Home 5	Reside	nce 6 Othe	er:
	٦t	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury Jul 30, 2009	28b. Time of 2029 hrs	f Injury 28c.	Injury at Work?  Yes 2 ✔ No		e how inju otorcyc	ary occurred dist involved	in motor vehicle
Division al or Attendi rs after death. al Director: /	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b	28e Place of Injury - At h	ome, farm, str	eet, factory, offi	ce building, etc.	accident 28f. Location or Town		ind Number or R	ural Route Number, City
ig is is it		4 Homicide determined	n: To the best of my knowled		urred at the time	e date and place	Harry S. Tru	ıman Dri	ive, Landover,	
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner:	On the basis of examination a and manner stated.	nd/or investig	ation, in my opi	nion, death occurr	ed at the time, da	te and pla	ace, and due to t	he cause(s)
F \$ E 8	Me	29b. Signature and title of certifier	· ·			cense number .C.M.E. OCM	*		Date signed (Ma)	onth, Day, Year)
		Moder W. K 30. Name and address of person who co	TR., w	1 23a)		.O.WI.E.		July		
R6		Theodore M. King, Jr., MD.			111 Penn	Street, Baltim	ore, MD 212	01		
	ate	31. Date filed (Month. Day Year) AUG 0 4 2009	32. Registrar's Signat	ure						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan				lental Hyg	giene		0.4.1.0.0
			1 - State Registrar		Ce	rtificate of	Death		leg. No.	ULY.	26 9 1
	Physicia	an	Decedent's Name (First, Middle, Last,		01170			2. Date of Dea Month	Day	2009	3. Time of Death 8:53P M
	/Medic	al			ONES	Ab City Town 0	L continue of Dogsth	JULY		unty of Death	0.551
	Examin	er	4a. Facility Name (If not institution, give 16010 EXCALIBUR			BOWIE	r Location of Death			NCE GEO	ORGE'S
-	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h	9. Birthp	lace (State or Foreign
	Director		313-22-5680	□M 2 <b>X</b> □F 83	Yrs.	Months Days	Hours Min.	(Month, Day SEPT. 2	4 192	5 IND	ÄNA
	ow I		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				1	0d. Inside City Limits
	Mary Fied	tor	MD PRINCE G	EORGE'S BOY	WIE						1 X Yes 2 No
	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	try?
	th wit	ral	16010 EXCALIBUR R	OAD B307		20716			USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
2	s afte	by Fi	1 ☐XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∭No If Yes, Give		1 □Yes 2 XNo	Specify:		Sp	pecify: B1	LACK
3	hour: tural'	ed b	15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occur	nation		16b. Kind	of Business/Inc	dustry
2	in 72 n "na n "na	plet	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most of work d)	ring			
7	filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene wither than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be rollified at	Completed	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)	PRO	GRAMMER			G0	VERNME	NT
2	e filec al Hyg lothe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,			
8	should be find Mental I marked of umatic eve	10	GUY W. JONES				VIRGIN		M.	PEAI	<u> </u>
=	and is m		19a. Informant's Name/Relationship (7) GUY A. JONES/BROT				and Number or Ru STREET N				
ע	f Health f Health item 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other place	col !	Date	20c. Locat	tion - City or To	wn, State
2	permit. Pages Department of Important: If its any injury or o		1 Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		NT CEMETI		1/2009	DAVID	SONVIL	LE,MARYLAND
<u> </u>	mit. partm sorta / inju		21. Signature of Fureral Service Licens			2. Name and Addre	ess of Facility	J. B. JE			
Ŏ	permi Depar Impor any ir		CA TYL		- 1	7474 LANI	OOVER ROA	D LANDOV	ER,MA	RYLAND	20785
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the deat one cause on each line.	th. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition	C	EREE	BROVASC	CLAR	ACCID	ENT		6 Cocake
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):			4:450			D It-
	_xanimei	<u>_</u>	Sequentially list conditions,	b. Due to (or as a conseq		20 CLED	SYSTEM	( 4717	ERTEN	Z(0N	2 months
	uted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			CLLED	TYPE	2 DIAB	ETE	MELLIM	2 moultis
	execu n and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a conseq		CECED		2 01110			
50	te be rsicia e buri	ical		d							
0	tifical ng phy as th	ledi									
מאַ	th cer endir r use	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnan	cv		230	d. Date of deliv	*
5	ie dea the at ned fo	Physician/Med	in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	4 ☐ Pregnant at time of a g ☐ Unknown		Other (specify)				Month	Day Year
Ē	hat th	Phy	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to t	the cause of death?
ה מ	signe signe d be o	d by		YROIDISM		,		1 🗆 \	Yes 2⊠	No 3∏ Pro	bably 4 🗌 Unknown
cords,	v requ	Completed		RESSION				24a, Was	an	24h Were auto	opsy findings available
ב ב	ne law e has ge 2 :	dw		C 22 104				autor perfo	rmed?	prior to co death?	ompletion of cause of
NII d	in: Th		25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		1 □ Yes	2 ☑ No
>	/sicia s cert direct	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpatie	ent 3 DOA Oth	nor:	ome 5 Resid		Other (Speci	ifv)
5	g Phy er thi	n:T	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time (			28d. Describe I			
	ath. rr: Aff	atio	1 ANatural 5 Pending 2 Accident investigation		,,,,,,,		Yes 2 □No				
2	or Affer de affer de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory, office		28f. Location (S City or Tox		Number or Rur	al Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination	owledge, dea	th occurred at the t	time, date and place	e, and due to the	cause(s) a	nd manner as	stated.
	the H nin 24 the Fi pplete	Medical	one)	and manner stated.				1			
<b>a</b> .	Son State	Σ	29b. Signature and title of certifier	1		29c. Licen			290. Date :	signed (Month,	Day, rear)
			NV should				0063	149	04	100/8	2007
2	-6		30. Name and address of person whole	completed cause of death (Iter	m 23a) (Type		Pan	1 6	1/1/20	MAN	20274

State Registrar

DHMH 17 Rev 1/2001

# Baltimore, Maryland 21215-0036

				pe or Print in State of Mary						
		•	State Registrar		Ce	rtificate of l	Death	R	eg. No. O	26191
	Physicia	an	1. Decedent's Name (First, Middle, Last)	0 1	3 T			2. Date of Deat Month	Day Yeer	3. Time of Death 1
100	/Medic	al	Ja  4a. Facility Name (If not institution, give str	mes Carrol	1 Jones	4h City Town or	Location of Death	August	4c. County of Dea	
	Examin	er	Union Hospital	eet and numbery		E1ktor			Cecil	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director		219-34-0455	<sup>M 2□ F</sup> 71	Yrs.	Months Days	Hours Min.	June 11,	, 1938   M	laryland
	yland how		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fs	cto	Maryland Cecil		E1kton					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	
	23a 23a ust b		129 Hollingsworth			21921			United	
	r deg	Funeral	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
36	or i	by F	1 ☐ Never Married 2 🏋 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: W	nite
9	hour tural	ed t	16b. Kind of Business							
15	in 72 n "na	plet	15. Decedent's Educa (Specify only highest grade of	completed)	(Give	kind of work done DO NOT use retired	during most of work d)	ing	Mobile	Home
21215-0036	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	As	sembler			Manufac	turing
שַ	be filed within 72 hours after death with the Maryland Hygiene.  d eithygiene.  d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be redified at	Вес	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i	Maiden Surname)	
Maryland	2 should be fi h and Mental I is marked of raumatic eve	2	Carroll Marshall J	ones			Emma R	ussell_		
ar	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type						r, City or Town, State,	
	s 1 and 2: of Health a item 27 is other trau		Sandra K. Jones/Wi			Hollingsv			On, MD Z1	921
Baltimore,	ges 1 If ite or of		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Re	moval from State		osition (Name of matory or other place	, mugu	ıst 10,		
Itim	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)			is & Co., I				hester, PA
Ba	permit. Pages Department of I Important: If Ite any Injury or of		21. Signature of Funeral Service Licenses	1	H	2. Name and Addre icks Home 03 W. Sto	for Fune	erals, P	.A. kton MD	21921
			23a. Part 1. Enter the disease, or complication	ations that caused the	death. Do not er	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximete Interval Between
	Obversion		Immediate Cause (Final	cause on each line.		- 01				Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a co	insequence of):	mest				
e de la	Examiner			Rilake	1 000	DARUE	$\sim$			
١	7 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	7				
	executed n and ial-transit	Examiner	that initiated events c.	COP	D.					
Ő,	a	_	resulting in death) Last	Due to (or as a co	nsequence of):					
9289	cate to physic the b	dica	d.					<u> </u>	<del></del>	
9 X	eath certific attending p for use as	/Me	IF FEMALE: 23	c. If yes, outcome of p	regnancy				23d. Date of d	elivery
Вох	atten for us	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐ Ectopic pregnand	су		Month	Day Year
O.	the d	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		(-,,-				
σ.	The law requires that the death certificate be ate has been signed by the attending physicion age 2 should be detached for use as the bu		Part Il Other significant conditions cont	ributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Records,	quires an sig ald be	ed by	Atmal Abr	Matron				1 □ Y	′es 2□No 3X	Probably 4 Unknown
၀	s bee	olete	Company of	real	disec	120		24a. Was	an 24b. Were	autopsy findings available o completion of cause of
Ä	'sician: The law s certificate has l lirector, page 2 s	Completed						perfo	rmed? death	es 2 No
Vital	ian: irtifica stor, p	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only o		
4	Pis P	To	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatie	ent 3 □ DOA Oti	ner: 4 Nursing H		dence 6 Other (S	pecify)
n O	ding Ph h. After thi funeral	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	ear) 28b. Time Injury	Wo	rk?	28d. Describe h	now injury occurred	
sio	tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	One Place of Injury	At home form		Yes 2 □No	28f Location /6	Street and Number or	Rural Route Number
Division	or At after d Direct In by	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc. (	Specify)	treet, factory, office		City or Tov		nurar noute rumon,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C	29a. Certifier 150 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of mer: On the basis of ex and manner stated	amination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)
	- > F O		Cologias	ull)		Do	00607	56	08/0	79/09
			30. Name and address of person who cor		h (Item 23a) (Type	e, Print)	Main	StS	ILLES	MO
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1500	Y I (CITY)			
	Regist		AUG 17 641	3 passage	2 B. Ci	Julie 1				

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#190 State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and State of Maryland / Department / 10 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Fime of Death Day Year Physician 2131 CHONG KIM KEUN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia Howard County Hospital Hours Min. April 1 if Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Year 1944 1**₹** M 2□ F Months 214-55-2138 65 Yrs Director Korea Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ?? is marked other than "natural", or items 23a or 28a-f shor traumatic event, the theologic Expurient must be a cultivated 1 ☐ Yes 2 X No Director Ellicott City Howard Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 9028 Town and Country Blvd. 21043 Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 22 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Asian 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Macy's Dept. Store Sales Associate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Han Im Lee Pages 1 and 2 should nent of Health and Mer ည Joong Bae Kim 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jassica Jessica Sunday/sister item 27 i <del>101</del> Evening Dew Drive Woodstock,Md. 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) St.Louis Cemetery 8/6/2009 Clarksville, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licens MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner LUNG CANCETE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of): inding physician ause as the burial Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy fo Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy PORTAL VEIN THROMBOSIS 2 4No 1 ☐ Yes 2 □ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 ☐ No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural Injury To the Hospital or Average within 24 hours after death.

To the Funeral Director: After the Funeral Director of the Di 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0043662 AUG 21 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 027 WILLIAM BOYCE OWAND (0) 31. Date filed (Month, Day, Year) Registrar's Signature 32. State AUG 0 4 2009 Registrar

Physici /Medi Examii

		Please	Type or Prin						-	_	ble.		
	for State Registrar		State of Ma	aryland / L		artment of h rtificate of		u iviei		. No. 2	109	2.5	193
	1. Decedent's Name	e (First, Middle, La	st)						Date of Death Month	Day	Year	3. Time of D	Seath
an	Mary	Alice Li	Lston					Ju	1y 3	30 2	009	11:3	0A ™
cal ier	4a. Facility Name (I	f not institution, giv	re street and number)		_	4b. City, Town, o	r Location of De	eath		4c. County	of Death		
ici	132 Ocean	n Parkway	7			Ocean P	ines			Worce	ster		
	5. Social Security N			e (In yrs. last bir	thday)	If Under 1 Year			Date of Birth		9. Birth	place (State or	Foreign
	287-40-63	1	□M 2 💢 F		Yrs.	Months Days	Hours M		(Month, Day, Your 1967), You		Cou O	intry)	-
	Usual Residence of			5.				рта	1011 219	1744		ш	
	10a. State	10b. County	<del>-</del>	10c. City, Town	n or Lo	ocation						10d. Inside City	/ Limits
ò	MD	Worcest	er	Berlin	ı							1 □Yes	2 📉 No
ecl	10e. Street and Nur	nhor				10f. Zip Code			10a	. Citizen of V	What Cou	intry?	
Funeral Director												,	
era	132 Ocean	n Parkway	T	- 1110	10	21811		0.40		ISA		inner tendine	
Š	11. Marital Status		12. Was Decedent I Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	iispanic Origin? an, Mexican, Pu	verto Rica	an, etc.)		e - Amer. ck, White,	ican Indian, etc.	
γF		ed 2X Married	1 □Yes 2 🟋 If Yes, Give	NO		1 □Yes 2 🕅 No	Specify:			Specify	⁄:Whi₁	te	
d b	3 Widowed	4 L Divorced	Year or Dates:										
ete	(Spec	15. Decedent's Ed hify only highest gra	ducation ade completed)	16a.	(Give	dent's Usual Occup kind of work done	during most of I	working	16	b. Kind of Bu	usiness/Ir	ndustry	
Completed by	Elementary/Seco	ndary (0-12)	College (1-4or 5	+)		DO NOT use retire	d)		_				
S	12		4	W:	rit	er				IO Ene			
Be	17. Father's Name (							,	irst, Middle, Mai	iden Surnan	ne)		
၉	Carl Wil	liam She	ekley				Alice	Mari	Le Ryan				
1.3	19a. Informant's Na			19b	. Mailir	ng Address (Street	and Number o	r Rural R	oute Number, C	ity or Town,	State, Zi	ip Code)	
	David Li	ston, Hu	sband	13:	2 0	cean Parl	wav. Oc	cean	Pines.	MD 2	1811		
1 2	20a. Method of Disp	position		20h Place of	Disno	sition (Name of	1	Date		c. Location -		own, State	
			Removal from State			matory or other plac open Cren		8/1/2	2009 F1	rankfo	rd.	DE	
	21. Signature of Fu	5 Other (Special		/		2. Name and Addre	1 -				-		
	21. Signature of Pu		isee of a com	-/		08 Willia			_		21811		
	1/1/	NITIG	MARCHAROL	_	-						.1011		
	shock, or hea	rt failure. List only	plications that caused one cause on each lir	ithe death. Do	not en	ter the mode of dyl	ig, such as can	rdiac or re	espiratory arresi	.,		Approximate Interval Betw Onset and D	veen
	Immediate Cause ( disease or condition		ASO	CUD	N	(I						Onbot and D	ou.ii
	resulting in death)		Due to (or as	a consequence	of):								
	Commentally list cor	aditions	$b = D_1$	abete	Ś								
ner	Sequentially list cor if any, leading to im cause. Enter Unde	mediate	,	a consequence	,								
Examine	Cause (Disease or that initiated events	injury	· H	a consequence	oid	emia							
Ě	resulting in death) L	_ast				_							
Completed by Physician/Medical			_d	yperte.	15i	'an							
edi				150	55,00								
2	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome							23d. Da	te of deli	very	
cia	in the past 12 1 Yes 2		1 ∐ Live birth 4 ☐ Pregnant a	2 ☐ Fetal death t time of death		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	У			Mo	onth	Day Y	ear
iysi	1 ☐ Yes 2 L 9 ☐ Unknown	<b>≯</b> <sup>NO</sup>	9 ☐ Unknown										
4	Part II. Other signif	icant conditions	contributing to death be	ut not resulting in	n the u	nderlying cause giv	en in Part 1.		23e. Did toba	cco use conf	tribute to	the cause of de	eath?
b	1.4	mohedo	ma						1 Yes	2 🗆 No	3□ Pro	obably 4∏U	nknown
tec		ERD						- 1		1			1000
ğ		EKD						_	24a. Was an autopsy	1	prior to c	topsy findings a ompletion of ca	vailable use of
ő									performe 1 □ Yes 2 5	ds.	death? 1 □ Yes	2 □No	
Be (	25. Was case refer	red to medical					26. Place of I	Death (C	heck only one)				
0	examiner? 1 □ Yes 2	No	Hospital: 1 ☐ Inpatie	ent 2 🗆 ER/Ou	ıtpatieı	nt 3 ☐ DOA Oth	er: 4 🗆 Nursin	ng Home	5 Residend	ce 6 □Oth	ner <i>(Spec</i>	eify)	
	27. Manner of Deat		28a. Date of Inju	ry 28b.	Time o		y at		. Describe how				
ıţi	1 Natural 2 ☐ Accident	5 ☐ Pending investigation	( <i>Month, Da<sub>i</sub></i>	y, rear)	njury	M 1	kr Yes 2∐No						
Ę	3 Suicide	6 Could not b	28e. Place of Inju	ury - At home, fa	rm, str	reet, factory, office		28f.	Location (Street	et and Numb	er or Ru	ral Route Numb	ber,
erti	4 ☐ Homicide	dotorrimod	building, et	c. (Specify)					City or Town, S	State)			
2	29a. Certifier	1 Certifying Pi	nysician: To the best	of my knowledge	e. deat	th occurred at the ti	me, date and p	olace, and	I due to the cau	ise(s) and m	anner as	stated.	
dice	(Check only one)		miner: On the basis o	f examination ar									
Medical Certification: To	29h Signature and	title of certifier				29c. Licens	e number		29d	. Date signe	d (Month	, Day, Year)	
100	1	\w1	440			dat	1.722	27		7	121	1 anria	,
	7 2		-, 10			au	e i p				101	1 2007	
	30. Name and addr	es of person who	completed cause of d	eath (Item 23a)	(Type,	Print)	0 (1)	147	2101	1			
	Daniell	6 O//	1110+	race tra	CL	UY. D	er lin,	~(1)	2181	ı			
te	31. Date filed (Mon	MIC O Q	2000 32. Registra	ars Signature	1	barker							
ar		HUU U O	LUUJ Jens	un p.	19	-							

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** DOROTHY **JEAN** LYNN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEROGE'S DOCTORS HOSPITAL ANHAM 8. Date of Birth (Month, Day, JULY 18 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours Min. MARYLAND 579-76-1719 54 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State show ms 23a or 28a-f sh must be notified Director 1 TYes 2 □ No PRINCE GEORGE'S FAIRMONT HEIGHTS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20743 1019 58th AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, its Neulon Examiner. Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 BLACK 1 □Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 11TH HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALMA JEAN HALL UNKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4919 SELTZER ROAD LANHAM, MARYLAND 20706 19a. Informant's Name/Relationship (Type. Print) AARON LYNN/SON 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD NATIONAL CEMETERY 8/3/2009 LAUREL, MARYLAND eture of Fundal Se J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** OU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MAA Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 cate has been signage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | perform 2 🖺 No 1 □Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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State

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Registrar

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· George

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD. 7500 Ha

MOD 58182

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07/27/09

, Suite 101A, Greenhelt, MD. 2010

			State of Maryland / Dep  State of Maryland / Dep  State of Maryland / Dep	eartment of Health and Nertificate of Death		ene 1. No. 20	09	26195
			Decedent's Name (First, Middle, Last)		2. Date of Death		.,	3. Time of Death
	Physicia		Marrage Eller Lieghty		July 30,	<sup>Day</sup> 2009	Year	12:10 p <sup>M</sup>
	/Medic Examin		Maryrose Ellen Liechty  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County	of Death	
	⊏ X diiiiii	eı	7144 Sixty Foot Rd.	Pittsville		Wicon	nico	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birth	place (State or Foreign
	Director		218-34-3291 1 M 2 F 71 Yrs.	Months Days Hours Min.	1/30/193		Penn	sylvania
	ō		Usual Residence of Decedent					
	how	_	10a. State 10b. County 10c. City, Town or I	ocation				10d. Inside City Limits
	a-f s	당	Maryland Wicomico Pittsvill	.e				1 🗌 Yes 2 🔼 No
	or 28	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of \	What Cou	ntry?
	23a	a	7144 Sixty Foot Rd.	21850		USA		
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spirif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - Ameri ck, White,	can Indian, etc.
2	or it		1 □ Never Married 2 🔀 Married 1 □ Yes 2 🛣 No	1 ☐ Yes 2 X No Specify:		Specif	,	
Ś	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				WI1.	ite
2	72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of worl DO NOT use retired)		6b. Kind of B	usiness/in	ldustry
V	vithin	m d	Elementary/Secondary (0-12) College (1-4or 5+)	rance Claims Clerk	,	nsurar	200	
V	Hygie Hygie Iher i		12 — Insu 17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma			
Ĕ	ntal led ed of	Be						
<u> </u>	2 should be filed within 72 hours after death with the Maryland a nand Memlar Hygiene. It and Memlar Hygiene is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations to refifted at	임	Alexander Ralph Vitelli  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	Ing Address (Street and Number or Ru	anor McCa			n Code)
2	d 2 sl th an 7 is r traur		,	Sixty Foot Rd. P:				
	1 and Health em 27 ther to		4			Oc. Location		
5	Pages nent of I int: If ite		1 Buriai 2 Li Cremation 3 Li Removal from State	position (Name of ematory or other place)	0 (0000 -			
	it. Per ritant ritant njury			y Crematory   08/0 22. Name and Address of Facility	3/2009 Sa	alisbu	cy,Ma	aryland
ם	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It at Medical Examination as realified at once.		11 12 1	Holloway Funeral H	ome PA			03.004
			23a. Part1. Enter the disease, or complications that caused the death. Do not e	501 Snow Hill Rd.			Land	21804 Approximate
			shock, or heart failure. List only one cause on each line.			51,		Interval Between Onset and Death
#.	Physician /Medical		resulting in death)	· Colon Co.	100			6 months
g .	Examiner		Due to (or as a consequence of):					
		J.	Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence of):					
	nsit	nin	cause. Enter Underlying Cause (Disease or injury					
•	exect	Examiner	that initiated events c.  The properties of the control of the con					
,00,	ficate be executed i physician and s the burial-transit	dical	<b>L</b> 4					
0	ificat g phy as the	edi	V					
5	n cert	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Da	ate of deli	very
0	death e atte	sician/Me	in the past 12 months?  1	B ☐ Ectopic pregnancy □ Other <i>(specify)</i>		M	onth	Day Year
į.	oy the	Phys	9 Unknown					
	s thai	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part 1.	23e. Did toba	acco use con	tribute to	the cause of death?
cords,	quire	d b			1 ☐ Yes	2 No	3☐ Pro	obably 4 Unknown
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ב	The late te has	E E			autopsy	ed?	death?	ompletion of cause of 2 □ No
2	an: T tifica: or, pi	ပိ	25. Was case referred to medical	26 Place of Dea	th (Check only one	)	I L tes	2 LINO
>	/sick	<u>m</u>	examiner?  1 Yes 2 100 Hospital: 1 Inpatient 2 ER/Outpat	Other:	lome 5 Desider		her (Spec	eifv)
5	g Phy er thi	n:To	27. Manuer of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how			,
5	ndin tth. :: Aft	atio	Matural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No				
	Atte	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm,	street, factory, office	28f. Location (Str. City or Town,		ber or Ru	ral Route Number,
5	alor s affe	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City of Town,	State)		
	pspit hours unera ly fille		29a. Certifier (Check only (Ch					
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical	one) wedical Examiner. On the basis of examination and/or	investigation, in my opinion, death occu	ined at the time, do	nte and place	, and due	to the oddso(s)
	Mithight Control	Σ	29b. Signature and title of certifier	29c. License number		d. Date sign		
			for ano.	030690		109	11.	2009
	OFN		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)				
l	0		Vences E, MARTIN M.D. 100	E. Carroll St.	5-1156	3-7,	My	2,801
	Sta		31. Date filed (Month, Day, Year)  AUG 13 2 2. Registrar's Signature  AUG 13 2 2 2. Registrar's Signature	berly				
	Registr	ar	KUO EL TIME	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST **Physician** LAMB FRANCIS LOUIS 2009 7:07 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kent Chester River Manor Chestertown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 18 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1**⊠**M 2□F Months Maryland Aug 220-32-8293 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28å-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Medical Examiner must be notified at 1XYes 2 □ No Chestertown Director MD Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21620 221 Mount Vernon Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Furniture Restorer Self-Employed 12 18. Mother's Name (First, Middle, Maiden Surname) anould be final the and Mental HV 17. Father's Name (First, Middle, Last) Be Walker Ball Lamb Susie Elsie VanZandt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. John Anthony Hurley (friehd) Box 172 21620 P.O. Chestertown, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kent Cremation 8/12/09 Smyrna, DE. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
110 Wort Cross St. Galena, MD. 21635 21. Signal of Funeral Servi MO0510 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedial Cause (Final 20 years HRONIC OBSTRUCTIVE PULMQUAILY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine g physician and is the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an The performed certificate 1 ☐Yes 2 ☑No Physician; director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 📉 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

DK

Maryland 21215-0036

Baltimore,

Box 68760

Ö

σ.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noble, M.D.Speer Rd. Helen A. 122 Chestertown, MD.

31. Date filed (Manth, Day, Year)

32. Registrar's Signature

1 - For State Registrar

Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ath Day	Year	3. Time of Death
/Medi		Hilda De Leal			41. O'h. Taum	or Location of De	Jul	1	2009	3:30PM
Examir	ner	4a. Facility Name (If not institution, give Laurel Region		1 6	1	lure	ain			George's
Funeral		5. Social Security Number 6. Se		ge (In yrs. last birthe	(ay) If Under 1 Year	If Under 24 H			9. Birthpl	ace (State or Foreign
Director			□M 2 <b>⊠</b> F	89 Yr	Months   Davs	Hours Mi	01/31/		Mex	
		Usual Residence of Decedent								
rylan	L	10a. State 10b. County		10c. City, Town of	r Location				10	od. Inside City Limits  1XYes 2 □ No
with the Maryland or 28a-f show	Director	MD Prince G	eorge's	Mt. Rai						
iff th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?
ath w	<u>ra</u>	3735 Wells Avenu			207				kico	
er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	<ol> <li>Was Decedent of I if Yes, specify Cub</li> </ol>	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Ra	ace - America ack, White, e	
s affe	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 🔀 If Yes, Give Year or Dates:		1. Yes 2 No			Spec	<sup>ify:</sup> Whit	0
27.5-UU36 hin 72 hours after death with the Maryland B. an "natural", or items 23a or 28a-f show Medical Evenine must be notified at	ed	15. Decedent's Ed			ecedent's Usual Occu		xican	16b. Kind of I		
	plet	(Specify only highest grad	de completed)		Give kind of work done ife. DO NOT use retire	during most of v	vorking			,
# # # #	Completed	Elementary/Secondary (0-12)	College (1-4or	· 1	Nurse			Healt	hcare	
ind Z be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Surna	ime)	
e de tage	To B	Rodolpho Chena				Elicia	Garcia			
VIATYIS  12 Should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (7	ype. Print)	19b. N	Mailing Address (Stree			er, City or Tow	n, State, Zip	Code)
C - C - C - S - S - S - S - S - S - S -		Zorina Magor - Da	ughter	722	5 Brunswic	k Circl	e Boynto	n Beacl	n, FL	33472
ST E		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla	ice)	Date	20c. Location	- City or To	wn, State
Baltimor permit. Pages Department of Important: If it any Injury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		9	coln Cemet	i	6/2009	Brentw	ood,	MD
AITI mit. partm oorta r Inju		21. Signature of Funeral Service Licen			22. Name and Addr	ess of Facility $f F$	t. Lincol	n Funer	ral Ho	me, Inc.
B a m g g		Whoma Mantagor	new Che	Home	3401 Blade	ensburg	Road Bre	ntwood	, MD 2	0722
1100		23a. Fart 1. Bhi ir the disease, scomp shock, of heart failure. List only of				-				Approximate Interval Between
Physician		Immediate Cause (Final	one or use on each							Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence of	p513				-	
Examiner			<b>Duc 10 (6) a</b>	LLAIN	ARY TR	415 7	NFECO	ion		
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	e a consequence of	L CAR	101				
outed d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		FATA	L CARL	DIAC ,	AR12477	imia		
<b>6U,</b> be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or a	s a consequence of						
<b>68 / 60</b> lifficate be of g physiciar as the burian	cal		.d							
certificate oding physise as the last	led					-				
BOX 68/6U, eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy	3 Ectopic pregnan	ICV			ate of delive	•
o dear dear dear dear dear	sicie	in the past 12 months? 1 □ Yes 2 ⊡ No		at time of death	5 ☐ Other (specify)	-		n n	Month	Day Year
at the	Physic	9 Unknown					-1			
C 2 2	by	Part II. Other significant conditions of	ontributing to death	but not resulting in t	he underlying cause gi	iven in Part I.				ne cause of death?
VITAI HECOYGS, ilcian: The law requires the certificate has been signe rector, page 2 should be d							_   10	Yes 2□No	3 ☐ Prob	abiy 4 Unknow
4ecc e law re has be	Completed						24a. Was		. Were auto	psy findings available
The The Sate has page	E						perfo	rmed2	death? 1 ☐ Yes	mpletion of cause of
VITAL IN ILLIA IN ILLIA	Be C	25. Was case referred to medical				26. Place of [	Death (Check only of			
yslci yslci is ce direc	.0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	tient 2 ER/Outp	atient 3 DOA Ot	her: 4 \(\sum \) Nursin	g Home 5 ☐ Resi	dence 6 🗆 C	ther (Specif	y)
g Phy g Phy ter this neral di		27. Manner of Death	28a. Date of In	njury 28b. Tir	ne of 28c. Inju	ury at	28d. Describe	how injury occi	urred	
DIVISION I or Attending after death. Director: Afte	atio	1 Natural 5 Pending 2 Accident investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		]Yes 2□No				
VIS Atte	III	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of f	njury - At home, farn etc. (Specify)	n, street, factory, office			Street and Nur. wn, State)	nber or Rura	al Route Number,
tal or rs aft	Certification: T		3.				4			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it					death occurred at the or investigation, in my					
he H in 24 he F	Medical	one)	and manner			opinion, dodari o				
Vith Vith Corr	Σ	29b. Signature and title of certifier	- 1		29c. Licer	nse number		29d. Date sign	ned (Month,	Day, Year)
			all	u	1	006376	7.3	7/3	11/09	7
0 3		30. Name and address of person who				i				2070'
L3_		Tsion Berhane, N		rel Region		7300	Van Dus	en Rd.	Lau	rel, MD
	ate	31. Date filed (Month, Day, Year)	32. Rec	strar's Signature	1					
Regist		AUG 0 4 2009 De	were po.	7						
DHMH 17 Rev 1/2	2001				RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Date of Death Month

3. Time of Death

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 To the Hospital

with the Maryland

death v

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001 Th

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 MO

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

00044373

29c. License number

K. Weidhur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph K. Weidner, Jr., M.D., 101 Colonial Way, Rising Sun, MD

31. Date filed (Month, Day, Year) **AUG 17** 

3 ☐ Suicide

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

## Please

Type or Print in	Black Indelibl	le Ink. Ei	nsure All	Copies A	re Legible
State of Maryla	ind / Departmen	nt of Heal	Ith and Me	ntal Hygi	ene

			For State Registrar	Oldie of Wi	ai yiai ic				Death	_	Reg. No	2009	26199
H	Physici	an	1. Decedent's Name (First, Middle, Last David Euston Mi	ddleton						2. Date of De Month		<sup>y</sup> 2009 Year	3. Time of Death 10:15 AM
44,	/Medio		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of Death		4c.	. County of Death	10113 11
1			52 Maple Avenue		(1			Kersv	ville If Under 24 Hrs.	O Date of Bir		rederick	place (State or Foreign
ı	Funeral Director		267-22-5559	ex 7. Ag M 2 □ F	e (In yrs. la	3 Yrs.	Months		Hours Min.	8. Date of Bir (Month, Da July 3	0, Year)	1926 Flor	itrv)
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation					1	0d. Inside City Limits
	a-fsh	ctor	MD Frederic	:k	Walke	ersvil	le						1 ☐ Yes 2 💆 No
	vith the	Dire	10e. Street and Number				10f. Zip	Code 793			10g. Ci	tizen of What Cour	ntry?
	Jeath v	Funeral Director	52 Maple Avenue	12. Was Decedent		3. 13.			ispanic Origin? (Span, Mexican, Puerto			14. Race - Americ	
98	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exercitors must be notified at	y Fur	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ I If Yes, Give	Vo		fYes,spe 1 □Yes		an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, Specify: Whi	
8	hours tural",	ed pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	1944-4	16a Deced	dent's Usu	al Occur	ation		16b. K	(ind of Business/Inc	
215	hin 72 e. an "na More	Completed by	(Specify only highest gra	de completed) College (1-4or 5	i+)	(Give life. L	kind of wo	ork done se retired	during most of work f)	king	F		
121	led wit Hygien her th ht, th	Co	12 17. Father's Name (First, Middle, Last)			Food	Serv.	ice l	Engineer  18. Mother's Nam	o (Firet Middle		staurant	
lanc	ld be fi lental H ked ot Ic ever	To Be	David Euston Midd		•				Elma Mae		, maider	r oamame)	
lary	2 shou and N <b>Is mar</b> aumat	۲	19a. Informant's Name/Relationship (	Type. Print)		1	_					or Town, State, Zip	Code)
e, ≤	1 and Health em 27 ther tr		Nancy S. Middleto 20a. Method of Disposition	n/wife	20h Pla				Walkersvi	lle, MD		793 ocation - City or To	wn. State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modral Exchin for must be neithed at once.		1 ☐ Burial 2 Macremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		Fina		ırney	Cre	matory 08	3/04/09	Woo	odbine, M	D
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licer	alth	MO1							P.O. Box	: 784 MD 21029
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	I the death, ne.	Do not ent	er the mo	de of dyir	TO 15 EASE	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	LXammer	e	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b Due to (or as	a consequ	ence of):							
	ocuted nd transit	Examiner	that initiated events	С									
60,	rificate be executed ng physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequ	ence of):							
68760,	tificate g phys as the	/ledical		d									
P.O. Box	eath ce attendii for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗆 Fetal	death 3	Ectopic     Other <i>(s</i>		у		11	23d. Date of delive Month	ery Day Year
	s that t ined by e detac	by Ph	Part II. Other significant conditions	ontributing to death b	ut not resul	Iting in the u	nderlying	cause giv	en in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
ord	law requires that the de as been signed by the 2 should be detached		Cittonic (	BSTRUCTI	UE I	PULMO	UARY	Dis	EASE	12	Yes 2	Prol	bably 4 Unknown
Sec	e law r has by je 2 sh	Completed	CARDIOM	YOPATHY						24a. Was auto		24b. Were auto prior to co death?	ppsy findings available empletion of cause of
tal	an; Th tificate or, pag		PERIPHERAL 25. Was case referred to medical	UASCUZA	2 01	SEASE			26. Place of Dea	1 □ Yes	2 🗹 No	o 1 □Yes	2 🗆 No
ž Z	hysici his cer I direct	To Be	examiner? 1 ☐ Yes 2 ☐ No			ER/Outpatier			er: 4 ☐ Nursing H			6 ☐ Other (Special	fy)
ouc	ding P h. After t funera	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry y, Year)	28b. Time of Injury	f .	28c. Injur Worl 1 □	yat k? Yes 2 □ No	28d. Describe	how inju	iry occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 290 Place of Ini	ury - At hor c. <i>(Specify</i>	me, farm, str			103 2 2 10	28f. Location ( City or To		nd Number or Run e)	al Route Number,
	Hospita 24 hours Funeral etely filled	Medical C		nysician: To the best niner: On the basis of and manner st	of examinat								
	To the within To the compl	Me	29b. Signature and title of certifier				29	c. Licens	e number		29d. Da	ate signed (Month,	
	$\bigcirc$		\	$\mathcal{M}$	NO			D	32171			8/3/0	۹
1	241)2		30. Name and address of person who			23a) (Type,		0 /	UALVERS	DIE A	ar Gr	21793	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Fegistr			acks	1	- 1, 5 Tep (5)	/ /	-1/	-1713	

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** August Gail Eileen Meredith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Memorial Hospital Easton If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 🔀 F Months Hours Nov. 2, 1950 Director 220-52-8413 58 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Actical Examinational boardings of Director Maryland
10e. Street and Number Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, Funeral 21529 26347 Line Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔀 No Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. <sup>Specify:</sup>Caucasian ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Meredith, Gai Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien. Important: If item 27 is marked other than any Injury or other traumatin survey. <u> Homemaker</u> Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Alice Liden Robinson Dawson George Hubbard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denton, Maryland 21629 Jerry L. Meredith Husband 26347 Line Road, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Concord Cemetery 8/7/2009 4 ☐ Donation 5 ☐ Other (Specify) nr Denton, Maryland

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans attending pl ed by the detached f sign pe certificate has birector, page 2 sl ours after death.

neral Director: After this certific filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

lical Examiner	Sequentially list of any, leading for cause. Enter Unic Cause (Disease of that initiated even resulting in death
Physiclan/Medical	IF FEMALE: 23b. Was decede in the past 1 1 □ Yes 2 9 Strinknow
þ	Part II. Other sign
Completed	
o Be	25. Was case reference examiner?

21. Signature of Funeral Service

shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	area le	AC	cole. A	Interval Between Onset and Death
disease or condition resulting in death)	a	4-500		-1001	
	Due to (or as a consequence of	" Laulus			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	1).			
that initiated events	· Typ	slalen	5		
resulting in death) Last	Due to (or as a consequence of	); CH	yperte	28182	\ .
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregna 5 ☐ Other (specify)			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause of	piven in Part I.	23e. Did tobacco u 1 ☐ Yes 2	ise contribute to the cause of death?  ☐ No 3☐ Probably 4☐ Unknow
				24a. Was an autopsy performed? 1 □ Yes 2 → Ho	24b. Were autopsy findings availab prior to completion of cause o death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of Death	n (Check only one)	
1 Yes 2 No	Hospital: 1 Impatient 2 ☐ ER/Ou	tpatient 3 ☐ DOA	ther: 4 🗆 Nursing Ho	me 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year)		ury at ork? □Yes 2□No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		m, street, factory, office		28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
	nysician: To the best of my knowledge miner: On the basis of examination an and manner stated.				
29b. Signature and title of certifier		29c. Lice	nse number	29d. Da	te signed (Month, Day, Year)

Moore Funeral Home, P.A.

S.Second St., Denton, Maryland 21629

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death

3. Time of Death

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

1 ☐ Yes 2 No

DPAOAM

Year

2009

Registrar

DHMH 17 Rev 1/2001

State

24 hours a Funeral C

within 24 hor To the Fune completely fi

Certification: T

Medical

31. Date filed (Month, Day,

30. Mame and address of person who completed cause of death (Item 33a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 18 per 1h g899 1-7-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2009 11:25 AMM 2 Eric Mende, III August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot 4080 Main Street Trappe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) June 17, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Davs Hours 1 ★M 2 ☐ F 215-58-5450 Maryland Director 60 June 1949 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or intems 23a or 28a-f show any or other traumatic event, it is Mo. Acel Exmini or nat to notified at any or other traumatic event, it is Mo. Acel Exmini or nat to notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 1 Yes 2 No Director Talbot Maryland Trappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 21673 4080 Main Street Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xfes 2 ☐ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X□No Specify Specify: Caucasian Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Supervisor Public Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Ellen** Eric Mende, Jr. Gordon ပ Grav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vonnie A. Mende yland 21673 20c. Location - City or Town, State wife 4080 Main Street, Trappe, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 8/3/2009 4 □ Donation 5 □ Other (Specify) Capitol Crematory Dover, Delaware 21. Signature of Funeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A Denton, Maryland 21629 noon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hour Vocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse wence of The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 s autopsy performed certificate trial ibrilla 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 □ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this upletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 29a, Certifier Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the within 2 29b. Signature and title of cert 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 55 5 Joean

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

AUG 0 4 2009

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egistrar's Signature

**ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1-Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5.13 PM 2009 HUM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2X F 47 01-17-1962 El Salvador 215-31-7968 Director Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City. Town or Location 10b. County 10a. State show must be notified at 1X Yes 2 □ No Director Silver Spring 28a-f MD Montgomery 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe items 23a or U.S.A. 3810 Palmira Lane 20906 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 11. Marital Status Black, White, etc. of Health and Mental Hygiene. Item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Specify: salvadoran Maryland 21215-0036 1X Yes 2 □ No Specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Housekeeper Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Guillermo Zuniga Oviedo Justamina Oviedo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) int of Health a t: If item 27 is or other tra 3810 Palmira Ln. Silver Spring, Maryland 20906 (Husband) Juan R. Maravilla Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or Gate of Heaven 08-03-09 Silver Spring, Maryland 5 Other (Specify) Skinallire of Fulk ral Ser 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. Z3a. Pay 1 Thief the disease, or complished, or heart failure. List only of Immediate or condition resulting in death) 3447 14th St. N.W. Washington, DC 20010. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to cause on each line. Approximate Interval Between Onset and Death **Physician** Otusian i /Medical Due to (or as a consequence of): Examiner In Section Funcal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or a consequence of): Metastat a cholungio avanon or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţ in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the at Id be detached f 2 🗌 No 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has b director, page 2 s 1 TYes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

JULIA AUG 0 4 2009

29b. Signature and title of certifier

one)

32. Registrar's Signature S. face

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARSH

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Dav. Year)

DHMH 17 Rev 1/2001

State Registrar 29c. License number

RES-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 262 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 25, 2009 Stewart Dewayne Myles July 1:11 Α /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Spa Creek Center Anne Arundel Annapolis 7. Age (In yrs. last birthday) 62 yrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec. 24, 19 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Dec. 216-44-5934 1946 DC **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State r than "natural", or items 23a or 28a-f sho 1 ☑ Yes 2 ☐ No Director Anne Arundel Harwood Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20776 United States 4167 Sands Road death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after XYes 2 No 1 ☐ Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates: Specify: African 1 ☐ Yes 2 🔀 No Specify. ۾ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other the any Injury or other tremment. Self-Employed Truck Driver 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Edward Myles, Sr. Helen Simms ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty A. Myles/ Spouse 1248 Washington Dr. Annapolis, Md. Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place)
Mary Land 20c. Location - City or Town, State 20a. Method of Disposition Ju1y 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 31, 2009 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Md. Veterans Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign ture of Funeral Sovice Dicense 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 6 months Colon Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar Due to (or as a consequence of) Box 68760, attending physician the death certificate be Physician/Medical the as nse yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ō in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death P.O. ☐Yes 2☐No ed by the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 🖾 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 

Nursing Home 5 

Residence 6 

Other (Specify) 1∐Yes 2.2MNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D32036 July 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary J. Sprouse, MD 2108 DiDonato Dr. Chester, Md. 21619 31. Date filed (Month, Day, Year) State 3 1 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	ii yiaiia i	•	tificate of			Reg. No.	2009	26201	ŀ
ь	hysicia	an	1. Decedent's Name (First, Middle, La.						2. Date of Dea Month AUG . 8		Year	3. Time of Death	
	/Medic		PAUL ROBERT N		AUG.8,		ounty of Death	8:50P M	_				
E	xamin	er	4a. Facility Name (If not institution, giv				ARLES						
Fu	ıneral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last	birthday)	COBB If Under 1 Year Months Days	ISLAND If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h	9. Birth	place (State or Foreign	i
	ector		220-42-2342	□M 2□F	74	Yrs.	IVIOTITIS Days	Tiodis Nati.	6-25-1		VA.		_
and	W		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	cation	<del></del>				10d. Inside City Limits	_
Maryl	-f sho											1 □Yes 2 <b>X</b> No	
h the	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	intry?	
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er dea	items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14	14. Race - American Indian, Black, White, etc.		
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G C I C filed withir Hygiene.	ther to		12 17. Father's Name (First, Middle, Last,	4		UN	ION ELE	CTRICIAI 18. Mother's Nam			W LOCA	.ь 26	_
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1 and 2 Health a	n 27 ii ier tra		GREGORY T.MILLI	ER-SON			BOX 372		ISLAND,				
Pages 1	If iter or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	ceme	etery, cren	sition (Name of natory or other place	ce) !	Date 1		ation - City or T		
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permit. Depart	any ir		21. Signature of Funeral Service Lice	M0047	9	1		FUNERA		CE,	P.A.		
			23a. Part 1. Enter the disease, or com	plications that caused	the death. D			A MD 21 ng, such as cardiac		rrest,		Approximate Interval Between	7
Phys	sician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	CC2	0	I ES	phase	aul.			Onset and Death	
/Me	edical		resulting in death)	a. Due to (or es	a consequen	ce of):	•	Pole	8-3				
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. e	y the a	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of deat	n 5L	Other (specify) _						
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v requires t	en sign uld be	ed by							1 🗆 '	Yes 2□	No 3 Pr	obably 4 ☐ Unknown	1
S S	as bee	plet							24a. Was		24b. Were au	topsy findings available completion of cause of	à
The T	page	Completed							perfo 1 □ Yes	rmed? 2 No	death? 1 ∐ Yes		
clan:	sertific actor,	Be (	25. Was case referred to medical examiner?	Hospital:			Lou	26. Place of Dea	th (Check onl	one			_
Phys	rthis cral dir	P.	1 Yes 2 No 27. Manner of Death	. 1 ☐ Inpatie	ent 2 ER	Outpatier b. Time o	IL 3 DOA		ome 5 Resi			cify)	_
ding .	After fune	tion	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	y, Year)	Injury	Wo	rk? ]Yes 2 □No	200, 5000,100	28d. Describe how injury occurred			
Atter Atter	ector by the	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ury - At home	, farm, str	eet, factory, office		28f. Location ( City or To		Number or Ru	ıral Route Number,	
tal or	al Dir	Certification:	4   Normale Building, etc. (Specify)										
LIVISION OF VILA THE COLOS, T.O. BOX 007 00, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.	To the Funeral Director. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one)  Check only one)	hysician: To the best miner: On the basis o	f examination	dge, deat n and/or in	th occurred at the to estigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
o the	omple	Med	29b. Signature and title of certifier	and manner sta	aicu.		29c. Licen	se number		29d. Date	e signed (Monti	h, Day, Year)	_
FS	- 0		1 12 Mar	h~			03	835	1	8	710	09	
			30. Name and address of person who	completed cause of d	eath (Item 23	_ 7	Print) Kris	sham Math	ur	1		1101	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		) (	rich		,	,D 9,	0676	
	Sta Registr		AUG 17	2009 Sener	un p	9. 1	tarke				<u>.</u>		

A<sup>®</sup> DHMH 17 Rev 1/2001 De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 2 Day 1. Decedent's Name (First, Middle, Last) 2009  $P^{M}$ Mary B. Owen Aug. 4:17 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ceci1 2449 Jacob Tome Hwy. Colora If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 1 M 2 XF July 18, 1921 North Carolina 166-12-9333 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Colora Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21917 United States 2449 Jacob Tome Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Storekeeper Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella M. Osborn Arthur H. Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2449 Jacob Tome Hwy., Colora, MD 21917 Allan Owen/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2009 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ture of uneral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one have on each line. Immediate cause (Final ute disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions

/Medical Examiner law requires that the death certificate be executed sician and burial-trans attending physician for use as the burial Division of Vital Records, P.O. Box 68760, signed by t I be detach icate has been si To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

<u>ک</u>

Completed

Be

**Funeral** 

Director

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Exactives must be rediffed at

**Physician** 

figure 1 fany, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	c. Due to (or s) a consector Due to (or as a consector).	y Artery	Disease		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlying	g cause given in Part I.		co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknow
				24a. Was an autopsy performed'	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	Hospital:			eath (Check only one)	
1  Yes 2  Mo  27. Manner of Death  1  Matural 5  Pending 2  Accident investigation	Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day, Year)	BR/Outpatient 3 ☐  28b. Time of Injury  M	28c. Injury at Work?  1 Yes 2 No	Home 5 M Residence 28d. Describe how in	e 6 Other (Specify) njury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifler	6 Som W		29c. License number  D 0033925	29d. 08/	Date signed (Month, Day, Year)
30. Name and address of person who Viver S. Thresh	- h - 1	m 23a) (Type, Print)  O Colonia	I Way Suite	B Rising	SUN, MD 21911

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 0 4 2009

			For State Registrar	State of M	aryland /	•	rtment of l	Health and N <i>Death</i>	-	giene Reg. No. 2	009	26208
	Disconic		1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea		Voar	3. Time of Death
	Physic /Medi		Joan Johnston Pre	uninger					August	Day 2	2009	4:19 Рм
1	Exami		4a. Facility Name (If not institution, give	e street and number)	)		4b. City, Town, c	or Location of Death		4c. Cou	nty of Death	
			11910 Central Ave	., Apt. 3	A		Ridgely				oline	
	Funeral		Social Security Number     6. S	ex 7. Aç □ M 2 🖟 F	ge (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th ly, Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		453-48-9445		69	Yrs.			Aug. 14	, 1939		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	ation				1	0d. Inside City Limits
	Mary f sho	ō	V1 1 C1		D: 1	. 1						1 ☐Yes 2 ☐ No
	the 1	rec	Maryland Caroline 10e. Street and Number		Ridg	дету	10f. Zip Code			10a, Citizen	of What Coun	trv?
	with Sa of	Ö	11010 Comtract Arro	A=+ 2	Λ				-	Ü		,
	Jeath	Funeral Director	11910 Central Ave	12. Was Decedent	Ever in U.S.	13. V	21660 Vas Decedent of H	Hispanic Origin? (Sp	ecify Yes or No	U.S.	A • Race - Americ	an Indian.
9	ifter o	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐				Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	E	Black, White, e	etc.
03	ours after death with the Marylar ral", or items 23a or 28a-f show Examinar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 2ÅNo	Specify:		Spe	cify: Whi	te
21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show pdical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16	Sa. Deced	ent's Usual Occup	pation	ina	16b. Kind o	f Business/Inc	
21	within iene. than "I	du	Elementary/Secondary (0-12)	College (1-4or !	5+)			during most of work d)	"ig	N/A		
	filed wi Hygier other th	Ş	unknown			D	isabled	r				
Maryland	s 1 and 2 should be filed within 72 hc of Health and Mental Hygiene. Item 27 is marked other than "natun other traumatic event, the Medical	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name		Maiden Surr	name)	
yla	should be fi and Mental I s marked ot umatic ever	ျှ	Unknown					Unknow				
Nar	2 sho n and is ma rauma	W S	19a. Informant's Name/Relationship (		100	39 L	vnnhaven	and Number or Rur Drive	ral Route Numb	er, City or To	wn, State, Zip	Code)
	and lealth m 27		Brian W. Preuning	er/Spouse		Hamp	ton, Vir	ginia 2	3666			
Baltimore,	Pages 1 nent of h int: if ite		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State			sition (Name of natory or other pla		Date		on - City or To	
Ħ	t. Pa traer tant:		4 ☐ Donation 5 ☐ Other (Specify	)	Chesa			ory Aug.				
Bai	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.	١.,	21. Signature of Funeral Service Licen	596				nd Helfen nset Ave.				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compand shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	d the death. Doine.	e :	er the mode of dyi	ng, such as cardiac	or the iratory a	rrest,	2	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence							
.O. Box 6	at the death certific by the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pregnand Other (specify)	су		23d.	Date of delive	ery Day <b>Y</b> ear
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death b	out not resulting	in the un	derlying cause giv	ven in Part I.	1	obacco use c ⁄es 2 ☐ No		ne cause of death? eably 4 🗆 Unknown
of Vital Records,		Completed	Chronic Chronic	phstn	vet	id	e Pu	Maria	24a. Was autor perfo 1 □ Yes	rmed?	prior to cor death?	psy findings available mpletion of cause of 2 \(\sime\) No
/ita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only o	ne)		
)	Physic this crall dire	욘	1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/C	<u> </u>	t 3 □ DOA Oth	ner: 4 Nursing Ho	ome 5 Resid	dence 6 🗆	Other (Specify	y)
ou c	ng ifter	Certification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. ay, <i>Year)</i>	. Time of Injury	28c. Inju Wor M 1	ryat rk? ∐Yes 2 ⊡No	28d. Describe I	now injury occ	curred	
isi	Attend death ctor: y the f	lical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ini	urv - At home	farm. stre	et, factory, office	ites Z LINO	28f Location /9	Street and Mu	mber or Rura	l Route Number,
Division	after Direct	erti	4 ☐ Homicide determined	building, et	c. (Specify)		,, ,		City or Tov	vn, State)	or or nurd	
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best iner: On the basis of and manner st	of examination a	ge, death and/or inv	occurred at the ti estigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and plac	I manner as s ce, and due to	stated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		)		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
	C > F 0		1 Jones	126/	11/	4+	173	1370	~	8-	3	0

State

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4	State 0	f Marylan		oartment of F e <i>rtificate of I</i>				10 00007
			1. Decedent's Name (First, Middle, Last)		C	er uncate of t	Jealli	2. Date of Deat		3. Time of Death
	nysicia	ın	Mary Catherine Pauza					Month Augus	Day Ye	wg 0408 M
	Medic xamin		4a. Facility Name (If not institution, give street and nu			4b. City, Town, o	Location of Death		4c. County of	Death
1				7. Age (In yrs.	) last hirthda	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1 1 0 1 9	Birthplace (State or Foreign Country)
	neral ector		5. Social Security Number   6. Sex   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \triangle K \)   1 \( \triangle M \)   2 \( \t	68	Yrs.	Months Days	Hours Min.	Jan. 18	Year) 1941	Maryland
			Usual Residence of Decedent	10c Cit	y, Town or	Location				10d. Inside City Limits
larylaı	notified at	ō	, our district		amden	Location				1 □Yes 2 □ No
the M	788-1	rect	DE Kent  10e. Street and Number	Uč	amden	10f. Zip Code		1	0g. Citizen of Wha	at Country?
h with	st be	a	2828 Willow Grove Road			19934			U.S.A.	
r deat	ems .	Funeral Director	11. Marital Status 12. Was Decc Armed Fo	edent Ever in U. prces? 2 ZNo	.S. 13	3. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
36 s afte	ral, or items 23a or Exeminer must be	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Gi  3 ☑ Widowed 4 ☐ Divorced Year or D	ve		1□Yes 2⊠No	Specify:		Specify:	White
<b>5-0036</b> 72 hours after death with the Maryland	natural,	ted	15. Decedent's Education		16a. De	cedent's Usual Occup ve kind of work done	pation during most of wor		16b. Kind of Busin	ness/Industry
<b>—</b> -		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (	1-4or 5+)	`life	e. DO NOT use retire	d)		Constru	ction
aryland 212 should be filed within and Mental Hygiene.	is marked other than aumatic event, the M	Co	17. Father's Name (First, Middle, Last)		Off	ice manage		ne (First, Middle, i		
anc ance fi	c evel	Be					Mary Kat			
Maryland 2 Id 2 should be filed lith and Mental Hyg	mari	ို	Wilmer Meissinger  19a. Informant's Name/Relationship (Type. Print)		19b. Ma	ailing Address (Street	and Number or Ri			ate, Zip Code)
Fe, Mg	ertra		Patricia Dolan/daughte		Gree	9 Dogwood nsboro, Ma	koad ryland	21639		7 . 01-11-
more	or oth		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from		Place of Dis cemetery, c en Ha	sposition (Name of rematory or other pla			20c. Location - Ci	
Mary Baltimore, Department of Hes	rtant:		4 ☐ Donation 5 ☐ Other (Specify)	(7.1.	moria	1 Park	and of Equility			nie, Maryland
Balti permit. Depart	Important: If item 27 is marked any Injury or other traumatic e once.		21. Signature of Funeral Service Licensee	L		Fleegle a 106 W. Su	and Helfe	nbein Fu Green	neral Ho sboro, M	me, PA aryland 21639
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the deat	th. Do not	enter the mode of dyi	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
Phys	ician		Immediate Cause (Final disease or condition	-41	cer	_				MONTE
	dical niner		resulting in death)  Due to	(or s a consec	quence of):					
		ě	Sequentially list conditions, if any, leading to immediate Due to	(or as a consec	quence of):					
cuted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underly in Cause (Disease or injury that initiated events							
0, e exe	ian ar urial-tı	EX	resulting in death) Last Due to	(or as a consec	quence of):					
38760, ficate be executed	I physician and sthe burial-transit	edical	d						- Indiana	
oertif	nding puse as	n/Me	IF FEMALE: 23c. If yes, or	utcome of pregn	ancy	• 🗆 =			23d. Date	of delivery
<b>. Bc</b>	e atte ed for u	iciai	in the past 12 months?	birth 2 Feta gnant at time of		3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Mont	th Day Year
P.O. Box	d by the	Physician/M	9 ☐ Unknown		oulting in th	o underlying course =	ven in Part I	23e Did to	bacco use contrib	oute to the cause of death?
ds, ires th	signer I be de		Part II. Other significant conditions contributing to Chrome Ob Structure	e au l	outing in th	an alibertyllig cause gl	se_	15(1)		B□ Probably 4□ Unknown
Division of Vital Records, lor Attending Physician: The law requires the after cleath.	been should	Completed by	Danel Films		-970	0		24a. Was		ere autopsy findings available
<b>Be</b>	te has age 2	dmo	Resec augus					autop perfo 1 ☐ Yes	rmed? de	for to completion of cause of eath? □Yes 2□No
ital ian: ⊺	rtificat tor, pa	Be C	25. Was case referred to medical				26. Place of De	ath (Check only o	7.	
of V hysici	his ce I direc					tilent 3 DOA		Home 5 ☐ Resid		
on o	After t unera	ion:	1 ☑ Natural 5 ☐ Pending (Mo	e of Injury onth, Day, Year)	28b. Tim Inju	ry   Wo	uryat ork? ⊒Yes 2 ⊒No	28d. Describe f	now injury occurre	3
isic Vittend death	y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At h	l nome, farm	, street, factory, office				r or Rural Route Number,
Div alor A	l Dire	Certification: To	4 Homicide determined built	ding, etc. <i>(Spe</i> c	cify)			City or Tov	vn, State)	
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certifully after death.	<b>-unera</b> ely fille		29a. Certifier 1 Certifying Physician: To the (Check only 2 Medical Examiner: On the	basis of examir	nowledge, on nation and/o	leath occurred at the or investigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and mai date and place, a	nner as stated. nd due to the cause(s)
o the l	o the l	Medical	one) and ma  29b. Signature and title of certifier	nner stated.			nse number			(Month, Day, Year)
F 3	i o		Man L. Chan	te	5	6	4043		Highs	+2,2009
			30. Name and address of person who completed ca		em 23a) (Ty	pe, Print) S. Cueshing	× 0	Sid.	141	2/60/
				Raistrar's Sign	nature -	s, wesmy	on st.	c os jun	1 100	- / 4
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 8 2009 32.	Registrar's Sign	A.	pour				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Inko Engure All Copies Are Legible. Amend 29d per phys. G896 110/23/05 Take All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 29, 2009 July 5:16 A M Margaret Anne Peer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dove House Hospice Westminster Carrol1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 7, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2XXF 217-34-1259 72 Feb. 1937 Washington, D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 United States 2250 Bear Den Road #305 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21XXNo Specify Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ruth Layton Francis Murray Bowie ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 748 Ardenwood Dr., Eldersburg, MD 21784 Kathryn Heaps / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date: July 1 ☐ Burial 2 IXICremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 21. Signature of Faneral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. Just only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** url disease or condition resulting in death) /Medical Due to (or as a consequence of): Q Examiner Min VO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions cor Division of Vital Records, \$ + U1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2**0** No 1 Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. Pate signed (Month, Day, Year) 7/31/ 29b. Signature an 29c. License numbe 2 2009 rson who completed cause of death (Item 23a) (Type, Print 30. Name KB 22 exande 31. Date filed (Month, Day, Year) 32. Registrar's Signature State > AUG n Registrar

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ii yiaiiu / L	•	ficate of			Reg. No.	2009	9 26209
ı	Physicia		1. Decedent's Name <i>(First, Middle, La VIVIAN</i>	,	KNEY				2. Date of De Month JULY	ath Day	Year 2009	3. Time of Death
2	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4	b. City, Town, or	Location of Deat			County of Dea	
	Examin	er	7905 GLENARD		,			ARDEN		PF	RINCE O	GEORGE'S
	Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last bir		If Under 1 Year	If Under 24 Hrs	8. Date of Bir (Month, Da	th	9. Bir	thplace (State or Foreign ountry)
	Director		578-30-3261 Usual Residence of Decedent	□м 2∏, F	83	Yrs.	Months Days	Hours Min.	MARCH			RGINIA
	land ow		10a. State 10b. County		10c. City, Town	or Locat	tion					10d. Inside City Limits
	Mary f sh	ţo	MD PRINCE	GEORGE 'S	GL	ENAR	DEN					1X∏ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	ountry?
	n with	a D	7905 GLENARDEN	PARKWAY			20785			USA		
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.S.	13. Wa		lispanic Origin? (S an, Mexican, Puer	Specify Yes or No		4. Race - Ame Black, Whit	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglone.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		Yes 21 No	Specify:	o riloan, cic.,		Specify: BI	
Maryland 21215-0036	"natura	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Deceder	nt's Usual Occup	ation during most of wo	rking	16b. Kin	d of Business	/Industry
12	within iene. than "	E C	Elementary/Secondary (0-12)	College (1-4or 5			SORTER	•/		COVI	ERNMENT	-
<b>d</b> 2	e filed val Hygid other vent, II		17. Father's Name (First, Middle, Last	)		LAME	SUNTER	18. Mother's Na	me (First, Middle			
lan	Mental Mental arked c	To Be	WILLIAM M. LEWIS	SR.				ANNIE	MARIE	LEWIS	S	
ary	2 should and Mer Is marke aumatic	_	19a. Informant's Name/Relationship	Type. Print)	19b	. Mailing	Address (Street	and Number or R	ural Route Numb	er, City or	Town, State,	Zip Code)
	1 and 2 Health a		WILLIAM SMITH/SO	N	10	00 S	PRUCE ST	CREET WA	LDORF, MA	RYLA	ND 2060	)1
Baltimore,	Pages 1 annung Pages		20a. Method of Disposition 1 □ Naurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci				ion <i>(Name of</i> tory or other plac CEMETERY	se) 8/4	Date / 2009		oation - City or OVER , M	r Town, State ARYLAND
Balti	permit. Page Department o Important; If any Injury or once.		21. Signature of Juneral Service Lice		1		Name and Addre	ss of Facility				ERAL HOME
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do						2212	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin								Onset and Death
	7Medical		disease or condition resulting in death)	a	a consequence	of):						
	Examiner			HTN		,-						
		je l	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence	of):						
	cutec nd ransit	Examiner	that initiated events	c. COPD								
Ó,	e exe ian a ırial-t		resulting in death) Last	Due to (or as	a consequence	of):						
68760,	tificate be executed ng physician and as the burial-transit	edical		d								
9	ertific ling p e as 1		IF FEMALE:									
Вох	death cer e attendir d for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal death		Ectopic pregnanc	Э		2	23d. Date of de Month	elivery Day Year
		Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at 9 □ Unknown	t time of death	5110	Other (specify) _					
σ.	that the ed by detac	, Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in	n the unde	erlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
Vital Records,	requires that the veen signed by the hould be detached	ed by	OSTEOPOROSIS						1 🗆	Yes 2	]No 3∏ F	Probably 4 Unknown
eco	aw as t	Completed	AORTIC VALVE						24a. Was			autopsy findings available completion of cause of
<u> </u>		Con	HYPERCHOLSTER	OLEMIA						ormed? 2 XNo	death? 1 ☐ Ye	s 2x No
/ita	ician; Th certificate ector, pag	Be	25. Was case referred to medical examiner?				100		ath (Check only	one)		
<u></u>	ding Physician; h. After this certific funeral director,		1☐XYes 2☐No		ent 2 ER/O	utpatient Time of		4 LI Nursing	Home 5 N Res			ecify)
n	ng ffel	i.i.oi	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	5 ☐ Pending (Month, Day, Year)			28c. Inju Wor	k?	28d. Describe	28d. Describe how injury occurred		
Sic	ten leat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		uny. At homo fo	rm otroo		Yes 2 □ No	28f   ocation	(Street an	d Number or F	Rural Route Number,
Division of	al or Attendli s after death. Il Director: A ed in by the fu	Certification: To	4 ☐ Homicide determined		c. (Specify)	ırııı, stree	i, lactory, office			wn, State		nurai rioute Number,
_	Hospit 24 hour Funera tely fille	Medical Co		hysician: To the best o	f examination a							
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner sta	ateu.		29c. Licens	se number		29d. Dat	e signed (Mor	nth, Day, Year)
	<b>₹</b> ₹ 8	_		Vimta	mo		D669				LY 30,	
						/Type P						
17	-10		30. Name and address of person who RACHAEL JOAN	•				E LANE LA	ARGO. MA	RYT.A1	ND 2077	7.4
0	Sta	te	31. Date filed (Month, Day, Year)				TOTALL TELL	- 141111 116	Lico, III		.5 2011	•
	Registr		JUL 3 1 2009 🛮	ever d.	ar's Signature							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra Amend#26. PerPhys. PGC8-3-09cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 0659 AM 09 rearson 07 )anie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PARK TAKOMA MD MONTGONERY COUNTY WASHINGTON ADVENTIST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months 89 Dec. 24, South Carolina 1919 Director 578-38-2384 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Examinating to a set the number of 1 X Yes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 924 48th Street NE 20019 United States Funeral death 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 🔀 No Specify: Q 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene, Is marked other than 12th Truck Driver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Pearson ပ Mary Pringle Pearson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 lt 924 48th Stret NE Washington, DC 20019 Tance Pearson/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1101 permit. Pages
Department of
Important: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 31, 2009 | Landover, Maryland 4 ☐Donation 5 ☐ Other (Specify) Harmony Memorial Park 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signiture of Funeral Servi Lice se 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Traising Home 5 ☐ Residence 6 ☐ Other (Specify) Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation s after doward Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Str

State Registrar 31. Date filed (Month, Day, Ye

YVISTTE

US MD 7600 CARROLL AVENUE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAKOMA PARK, MD

		DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	P / E
A	RR	Io the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	hys /Me Exa
Re	5	To the Funeral Director: After this certificate has been signed by the attending physician and	sici edie mir
St gist		compietely lilled it by the furefra director, page z should be detached for use as the buria-transit.	an cal ner

	1 - State Registrar	Certif	icate of Death		Reç	j. No.			
	Decedent's Name (First, Middle, Last)	Danv	Marie	2.	Date of Death Month	Day Year	3. Time of Death		
ın al -	CLAKUNDA	IHKE	S-MAYE	( )	July d	र्षेष्ठ अळेषु	15:05 M		
er	4a. Facility Name (If not institution, give street and number)		b. City, Town, or Location	or Death		4c. County of Death			
	The Johns Hopkins Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last				Date of Birth	9. Birth	place (State or Foreign		
	214-04-5995 1 M 2 X 34		onths Days Hours	Min.	(Month, Day, Y	,1974 Was	sh.,DC		
	Usual Residence of Decedent	-					10d. Inside City Limits		
'n		Fown or Locat					1 ☐ Yes 2 ☐ No		
ect	MD Prince George's Che		am 10f. Zip-Code		100	g. Citizen of What Cou	ntrv?		
ä	11005 Westwood Drive		20623		10,	US	,		
nera	11 Marital Status 12, Was Decedent Ever in U.S.	13. Wa	s Decedent of Hispanic O	rigin? (Specify	Yes or No-	14. Race - Amer			
Ξ.	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give		es, specify Cuban, Mexica Yes 2 No <i>Specify</i>		ari, etc.)	Black, White  Specify: B	_		
d b	3 Widowed 4 Divorced Year or Dates:				-	6b. Kind of Business/l			
Completed by Funeral Director	(Specify only highest grade completed)	(Give kin	t's Usual Occupation d of work done during ma NOT use retired)	st of working	1	ob. Killa of Busilless/i	ilidustry		
omp	Elementary/Secondary (0-12) College (1-4 or 5+)		or of Fiel	d Ope	ration	ns Pris	ate		
Be C	17. Father's Name (First, Middle, Last)					aiden Surname)			
일	Clarence C. Parks		Ger	aldin	e Coe				
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street and Num	ber or Rural F	Route Number,	City or Town, State, Z.	p Code)		
		3602	Hillary Ct		er Mai	clboro, MD	20772		
	1 Burial 2 Cremation 3 Removal from State		on (Name of or only or other place) on Cemetery	Date		clinton, M			
	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenses)		Iame and Address of Faci						
	Kimberly (Briscoe-101)	200		BKT2			HOME, P.A. 20601		
23a. P. 1. Enter the discontinuous complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									
	shi ck, or heart failure. List only one cause on each line.	MOR	they				Interval Between Onset and Death		
	disease or condition resulting in death)  a. Due to (or as a consequence)								
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nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):							
Exan	that initiated events C	nce of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d									
<b>l</b> edi									
	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal d		ctopic pregnancy			23d. Date of del	,		
sici	1 Yes 2 No 4 Pregnant at time of dear		other (specify)	•		Month	Day Year		
Completed by Physician	9 Unknown \ Part II. Other significant conditions contributing to death but not result	ting in the use	Aerlying cause given in Po	art I	23e Did tob	acco use contribute to	the cause of death?		
by	Part II. Other significant continuous continuous to death but not result	ang in the and	errying cause given in ra	u ( 1.	1 □ Yes				
etec					24a. Was an	24b. Were au	topsy findings available		
Id II					autopsy perform	ed? prior to death?	completion of cause of		
ပိ	25. Was case referred to medical		26. Plac	ce of Death	1 ☐ Yes 2 Theck only one,	No 1 ☐ Yes	2 🗆 No		
o Be	examiner?								
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
satic	2 Accident investigation M 1 Yes 2 No								
ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	e, tarm, street	, factory, office	281	City or Town,		Irai Route Number,		
20	29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death o	ccurred at the time, date	and place, and	d due to the ca	use(s) and manner as	stated.		
dica	(check only one) 2 Medical Examiner: On the basis of examinatio and manner stated.	n and/or inves	stigation, in my opinion, d	leath occurred	at the time, da	ate and place, and du	e to the cause(s)		
Me	29b. Signature and title of certifier		29c. License number		29	d. Date signed (Month	n, Day, Year)		
	I tota Knot		1)4104	17		120109			
	30. Name includes of person who completed cause of death (Item 2	23a) (Type, Pr	int)	202 1:		- Ct D-14!	MD 04007		
	31. Date filed (Month, Day, Year)  32. Registrar's Signatur	re	<u></u>	600 No	ortn Woll	e St, Baltimo	ore, MD, 21287		
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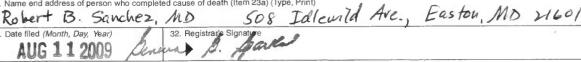
DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

31. Date filed (Month, Day, Year) AUG 1 1 2009



30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30 2009 Month Physician 2:20 P M July Mary Norma Rau /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rerlin MD
If Under 1 Year | If Under 24 Hrs. Worcester Berlin Nursing Home Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2√□ F 83 July 25 1926 MD Director 212-22-8363 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Its Medical Examinat must be redified at any injury or other traumatic event, Its Medical Examinat must be redified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Berlin MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 Funeral 5 Laport Ct Worcester 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Grauer John Patrick Dignan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laport Ct Berlin, MD 21811 Charles B Rau Mary Rau, Mar) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Da 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State August 4th |Baltimore Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the d. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and Due to (or as a consequence of) the attending physician a Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐ Yes 1 □Yes 2 **N**o To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes / 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 V atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

AUG 03

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death State
Registrar Amend#25PerMEPGC8-4-09cr 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2336 **Physician** RORTE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince 60005 Cheverlo 6 tal Center Hospi corges Prince If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign 8. Date of Birth (Month, Day, DEC. 18 Age (In yrs. last birthday) 5. Social Security Number 6. Sex WASHINGTON, DC Hours Months Days **Funeral** 1□M 2 🔀 F 1964 Yrs. 44 578-06-8491 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location death with the Maryland 10b. County 10a. State rai', or items 23a or 28a-f ehow Examiner must be notified at Yes 2 No PRINCE GEORGE'S LANDOVER Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 2108 E. MARLBORO AVENUE # 11 20785 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: BLACK within 72 hours after 1 X Never Married 2 Married Specify: 1 ☐ Yes 2X No Specify Baltimore, Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced natural 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) Elementary/Secondary (0-12) then PRIVATE filed with Hygiene. HOMEMAKER 12TH 18. Mother's Name (First, Middle, Meiden Sumame) other 17. Father's Name (First, Middle, Last) Be to and 2 should be fill Health and Mental H CAROL A. SMITH BAXTER L. RORIE traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2108 E. MARLBORO AVENUE #11 LANDOVER, MARYLAND 20785 MARY E. HARROD/SISTER Pages 1 and 2 ment of Health a other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permil. Page Department of Important: If any injury or ŏ RIVERDALE, MARYLAND 7/31/2009 RIVERDALE CREMATORY J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Europe at Service Censee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ∟xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Uniderfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner OUATIAN be executed burial-tran and Due to (or as a consequence of) Box 68760. physicien Physician/Medical death certificate the as the attending IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death use 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? ŏ 4 Pregnant at time of death 5 Other (specify) O. detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 2 4 Munknown Records, 1 ☐ Yes 2 ☐ No 3 Probably å Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2 No 1 Yes 2 No certificate espirato Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 2 ER/Outpatient 3 DOA 1 Inpatient 1 XYes Z Certification: To 28d. Describe how injury occurred SIFUCE this rossing et 28c. Injury at Work? 28b. Time of Date of Injury (Month, Day Year) 27. Manner of Death After Rele 201 5 Pending 1 Natural Russe of Injury - At home, larm, street, factory, office building, etc. (Specify) 2 1No 1 TYes death. investigation 2 Accident 28f. Location (Street and Number of Rural Go City or Town, State) after death Director: 6 Could not be determined 3 Suicide filled in by 4 | Homicide MAYE 0 ha 10.2 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Hospitel 24 hours a 29a. Certifie Medical (Check only one) completely within 2 and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier d cause of death (Item 23a) (Type, Print) 00 31, Date filed (Month, Day Fear) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Dav Month **Physician** July Ernestina Robinson 31 2009 2:40 Μ, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Sept. 30,1933 Dominica Director 215-47-3520 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show XXYes 2 □ No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the "hadral Examiner must be notified Director Beltsville Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Commonwealt filed within 72 hours after death with 20705 of Dominica 5320 Brewer Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes ŽXNo Specify: Specify: Black <u>Ş</u> 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.

7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arnold Floyd Leonie James ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau Annabella Robinson (daughter) 5320 Brewer Rd. Beltsville, MD 20705 20c. Location - City or Town, State Marigot Commonwealth 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 5 □Other (Specify) Marigot Meth.Ch. Cem. 8/22/09 of Dominica 4 Donation 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. firmediate Cause (Final disease or condition resulting in death) **Physician** ardianyo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12-months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö σ. signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>გ</u> 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Physician: The certificate 1 ☐Yes 2 ☐ No Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 X Natural 5 Pending investigation death. n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in funeral fill 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) completely

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State Registrar

29b. Signature and title of certifier

address\_of person who completed cause of death (Item 23a) (Type, Print) AN

and manner stated.

within 2

29c. License number D45760 29d. Date signed (Month, Day, Year)

Amend Item 10g per inf., g895,09/28/09dhb
Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.
amend item 1 per doc, 17,18 per fh g894 8-21-09 vt
State of Maryland / partimetry 1 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 1997, 19 For State Registrar 2. Date of Death Pytneva Aleksandra Yefimouna AKA Aleksandra Y. Ryzhova 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29 2009 9:23 A. July Aleksandra /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8703 Good Luck Rd. Prince Georges Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours Min 1 🗆 M 26 1927 Director 81 Russia 218-73-4429 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show 1\_Yes 2 No event, the Medical Examiner must be notified Director 28a-f Maryland Prince Georges Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a 8703 Good Luck Rd. 20706 U.S.A. Russia Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status 72 hours after 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify à 3 ₩ Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Hame 2 should be filed w h and Mental Hygien is marked other th 12 Homemaker 17. Father's Name (First, Middle, Last)
Pytnev Yefim Mikailovich 18. Mother's Name (First, Middle, Maiden Surname) Pytneva Ksenia Sofronovna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Valentina Belaineh (Daughter) 8703 Good Luck Rd. Lanham, MD 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Epiphany Church Cem. 08/03/09 Forestville, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature Funeral Service Licenses sal 9013 Annapolis Rd. Lanham, Maryland 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiamyopathy /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine executed burial-trar Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical the SS IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknowi signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Carcinoma Colon page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐Yes 2 ☐ No 1 □Yes 24 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) \( \mathbf{Y} \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2√☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide \*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 31, 2009 D61446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9470 Annapolis Rd. #315 Lanham, MD 20706 Kalaiselvi Ayyanar 32. Registrar State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		1 - State Registrar	State of Maryla		tificate of De		Re	eg. No. 200	9 26217
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Blanche	C.	Rockwe	ell		2. Date of Death Month Aug 1	0, 2009 Ye	ar 11:00am <sup>M</sup>
Examin		4a. Facility Name (If not institution, give Golden Living Ce			4b. City, Town, or Lo			4c. County of E	Peath
Funeral Director		5. Social Security Number 6. Set 214-52-1809  Usual Residence of Decedent	7. Age (In )	rrs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jun 3,		Birthplace (State or Foreign Country) MD
a-f show	ctor	10a. State 10b. County Allega		City, Town or Loc Cun	nberland				10d. Inside City Limits 1 □ Yes 2 □ No
23a or 28 ust be not	ral Director	10e. Street and Number 134 New Hampsh	nire Avenue		10f. Zip Code	21502	10	og. Citizen of What	
0,1	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Wildowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1	l II	Vas Decedent of Hispa Yes, specify Cuban, I □Yes 2 No S	anic Origin? (Spe Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. <b>white</b>
jene. r than "natu It e Madical	Completed	15. Decedent's Educify only highest grade  Elementary/Secondary (0-12)		(Give I	ent's Usual Occupatic kind of work done duri IO NOT use retired)	on ing most of workir	ng	own hon	
Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)  Harvey Rigglen	nan			3. Mother's Name	(First, Middle, M	faiden Surname)	
er traums		19a. Informant's Name/Relationship (Ty) Barbara Logsdon	pe. Print) daugh	ter 19b. Mailin	g Address (Street and 4 New Ham	Number or Rura		City or Town, State	ne, Zip Code) MD 21502
tment of He tant: If iten jury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	p. Place of Dispos cemetery, crem Abe Cemet	sition (Name of latory or other place)  ery	D	ate 2 8/12/2009	Short G	
Depart Import any in		21. Signature of Funeral Service License		22.	Name and Address of Scarpelli 108 Virgi			nd, MD 2150	2
nysician Medical kaminer		23a. Pan11 Inter the risea e. / r com listor, or he rit ailure. List only in Immediate Caus (Final disease or condition resulting in death)	ation that coused the de e cause on each line.  Due to (or as a cons	15	er the mode of dying, s	such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons				-		
attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of preduced to the second of the secon	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
be q	2	Part II. Other significant conditions con	tributing to death but not r	esulting in the un	derlying cause given in	n Part I.	23e. Did tob		e to the cause of death?  Probably 4  Unknown
certificate has be ector, page 2 sho	Completed					<del></del>	24a. Was an autopsy perform	/ prior ne <b>t</b> i? deatl	e autopsy findings available to completion of cause of n?
er this certiferal director	9 0	25. Was case referred to medical examiner?  1 Yes 22 No  27. Manner of Death	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	Other	-	ne 5 Reside	nce 6 Other (5	Specify)
within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	↑ Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be 4  Homicide determined	(Month, Day, Year)  28e. Place of Injury - At building, etc. (Spe	Injury	M 1 ☐ Yes	: 2 □ No		eet and Number o	r Rural Route Number,
the Funera	edical	one) 21 Medical Examin	ician: To the best of my ker: On the basis of examinand manner stated.	nowledge, death ination and/or inv	occurred at the time, estigation, in my opinion	date and place, a on, death occurre	and due to the ca	ause(s) and manne	er as stated. due to the cause(s)
To		29b. Signature and title of certifier				o 3328		dd. Date signed (M	onth, Day, Year)
01		30. Name and address of Morson who cor SUNIL GUPTA 31. Date filed (Month, Day, Year)	, M.D. (	e25 KI	PUT AVE	. Cum	BERVA	m, mo	) alsoa
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 8:45PM 1 2009 August Herman William Short, III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Caroline 25625 Goldsboro Road Henderson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** 1944 65 Yrs. Maryland 11, 213-44-0250 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, The Medical Ereminer must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Caroline Henderson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21640 25625 Goldsboro Road Funeral 12. Was Decedent Ever in U.S. Acqued Forces? 1 ⊠Yes 2 □ No Army If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bridge Construction 11 Carpenter n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Ruth Anna Biles Herman William Short, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25625 Goldsboro Road 19a. Informant's Name/Relationship (Type. Print) Ida Mae Short/Spouse 21640 Henderson, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 5, 2009 Greensboro, Maryland Greensboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA 106 W. Sunset Ave., Greensboro, Maryland 21639 Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗆 No 1 ☐Yes 2 ☐ No 1 ☐ Yes of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Mesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and ad ress of person who complet cause of death (Item 23a)

State

HMH 17 Rev 1/2001

#340

Registrar

Year) AUG 0 6 2009

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 05 M Day Year **Physician** 01 200 Hal V. Sword /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice HOOMICO Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age 91 (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F Michigan 5/4/1918 Director 375**-**09**-**1400 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I'm Midical Evan in a that is nathed at 1 ☐ Yes 2 ☐ No Director MD Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number <u>USA</u> Funeral 12545 River Run Lane unit 67 21811 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or iten any injury or other traumatic event 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 ☑ No Specify: Specify: White β 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Food Products Ind. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Skeels 2 Carl Sword 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>12545 River Run Lane Berlin,</u> <u>Mary Miller</u> Daughter MD 21811 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 5 ☐Other (Specify) 4 Donation 8/4/2009 Frankford DE Cape Henlopen Crem. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature / Funeral Service 108 William St. Berlin, MD 21811 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULLULARY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence offs Examine burial-transit law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 | Yes 2 | 1 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? √ Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. 29d Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001

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Human

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Denove B. Jack

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		For State Registrar	State of Mary		artment of H <i>rtificate of L</i>			ene Z U g. No.	U	2022
		Decedent's Name (First, Middle, Last)					2. Date of Death	Day	Va 0.5	3. Time of Death
Physic /Medi		Jean Riddle Smith					Month 7	30 20	)09	10:15 A <sup>M</sup>
Exami		4a. Facility Name (If not institution, give s 10849 Bellerive La	•		4b. City, Town, or Berlin		1	4c. County of		•
Funeral Director		Social Security Number 6. Sex		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)			ace (State or Foreigi
		Usual Residence of Decedent								
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vith th	Dir	10e. Street and Number			10f. Zip Code	11	10	ng. Citizen of Wh USA	nat Coun	try ?
s 238	eral	10849 Bellerive La	3.NE 12. Was Decedent Ever	in II C 12 1	218 Was Decedent of H		nacify Yas or No-	14. Race	- Americ	an Indian
Judge the filed within 72 hours after death with the Maryland and Mental Hygiene.  marked other than "natural" or items 23a or 28a-f show matte event, the Medical Examination institution indiffed at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 □Yes 2 🛣 No	Specify:	o Rican, etc.)		, White, e	tc.
n 72 hou "nature edicel E	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	6b. Kind of Bus	iness/Ind	lustry
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should be f and Mental I s marked of	To B	James Truss				Ethel	Robinson			
2 shou and N is mai	_	19a. Informant's Name/Relationship (Ty	oe. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, S	State, Zip	Code)
ss 1 and 2. of Health a item 27 is		James Smith / hus	oand	1084	9 Belleri	ve Lane,	Berlin,			
of He		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac			20c. Location - C	•	
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permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Fineral Service License	ee	22	2. Name and Addres	am St.,	urbage Fi Berlin, N	neral H 10 28111	lome	
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To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Cer	(Check only 2 Medical Exami	siclan: To the best of m ner: On the basis of exa and manner stated	amination and/or ir	nvestigation, in my	opinion, death occ	urred at the time, d	ate and place, a	ind due to	the cause(s)
omple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed	(Month,	Day, Year)
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DH 6		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Print) 4020	OCEMV	Cery Bi	ND. (3	M	en,un
	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	/		4		2	1811

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

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				State of Ivia	•	Certificate of			leg. No.	الساة	
			1. Decedent's Name (First, Middle, Les	t)				2. Date of Dee Month		Year	3. Time of Death
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	th wit	a	15 S. Beaumont Av	venue		21228			USA_		
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Maryland	should be fand Mental is a marked of umatic eve	2	Charles Sarm					e Garnes			
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Baltimore,	Pages nent of int: If It iny or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemete	y, crematory or other pla awn Cemeter	,	1.	Woodlawn		
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	To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	Iner: On the besis o	f examination an	e, death occurred at the tod/or investigation, in my	opinion, death occu	rred at the time,	date and place, a	and due t	to the cause(s)
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	4+114		30. Name and address of person who	ALLA(15	leath (Item 23e)	(Type, Print) 9005 KI	LBRIDE	RO A	RETIN	wn	Day, Year) , 2009 E, Cup 2128
	Sta		31. Dete filed (Month, Day, Year)	32. Region	ar's Signeture	6					,
	Registr	ar	JUL 30	2009 Ken	our p	. park					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10, 2009 12:11 NPM Shumaker Aug. J. Granville /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rawlings 17803 McMullen Hwy. Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 4, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) · 1915 **Funeral** Days Months Hours 187 M 2 7 F 94 217-10-7761 Aug. Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Rawlings Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21557 S. U. Α. 17803 McMullen Hwy. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ②XYes 2 □ No 1942 If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 6 permit. Pages 1 and 2 should be filec Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie E. (Defibaugh) Grover C. Shumaker ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 North Lakewood Dr., Ridgeley, WV 26753 P.O.A. John Wagoner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Lawn Mem Pk Aug 13 09 LaVale, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, open 21502 1302 National Hwy., LaVale, Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the shock, or heart failule. List only one of use on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** YRS ALZHIEMERS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. E. No. Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) JYes 2□No the detached 9 Unknown þ The law requires that signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BRILLA TON 1 🔲 Yes 3 Probably 4 □Unknown Completed YPENTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe has page this certificate Yes 2 No 1 To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA P within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg Donaldson, Braddock Medical Group, 912 Seton Dr., Cumberland MD 21502 31. Date filed (Month Registrar's Signature Day Year) State BURG

DHMH 17 Rev 1/2001

Registrar

OR.

Pamela E. Southall, MD Assistant Medical Examiner

31. Date filed (Mogth 2000)

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a)

State Registrar 111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Barbara Jean Tindall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 8,1948 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🖵 F Illinois Yrs. 321-44-0149 61 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ir than "natural", or items 23a or 28a-f sho Maugansville Md. Washington 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21767 14015 Village Mill Dr. Apt.D-3 U.S.AFuneral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Home permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygit Important: If item 27 is marked other any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean D. Allen Theodore Dzieciol ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Tindall (Husband) 14015 Village Mill Dr. Apt.D-3 Maugansville,Md.21767 Aug. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Md. Smithsburg Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 AVIS Approximate Interval Between Onset and Death xtt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner UNCONTR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 □Yes 2 🔀 No signed by the 9 Dunknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA မ filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier :ompletely (Check only one)

State Registrar

Medic

29b. Signature and title of certifier

MOHAMME

oncummed 31. Date filed (Month, Day, Year)

AUG L 6

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66892

29d. Date signed (Month, Day, Year)

East Antietamst. Hyserstown, mo21740

and manner stated.

32. Registrar's Signature

30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 10:48A DIERDRE TWEEDY AUGUST 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5-26-1959 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Davs Hours Min. 1 □ M 2 🗷 F 223-90-8548 50 Director VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evandre. 1 ☐ Yes 2 🛛 No Director MD Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 1310 Peachtree Court 21703 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auditor Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifton W. Tweedy Emma Cheatham ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once. 1609 Forest Chapel Road Pamplin VA 23958 Marva T. Thornton Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State St. Luke Baptist Ch 8-12-09 Brookneal, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Ser 106 East CHurch Street Frederick, MD 21701 M01176 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis dou /Medical Due to (or as a consequence of): Examiner netostat Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 2 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔏 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 ONR Michael Tolino, MD Year) 31. Date filed (Month) 32. Régistrar's Signature State AUG Registrar

DY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended item = For #15, per F. Home 8/5/09 aryland / Department of Health and Mental Hygiene Amended item = Registrar #8, per F. Home, 8/5/09, Certificate of Death WCHD, E.T Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician  $7/31/2009^{D}$ 6:05 P M John Elmon Veader /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester <u> Atlantic General Hospital</u> Berlin If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth 946/1924 Birthplace (State or Foreign (Month, Day, 946/1924) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2 □ F Yrs. Director 9/16/1924 Ohio 236-30-5009 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, its Medical Examination of conflict at 1 ☐ Yes 2 ☐ No Director Berlin MDWorcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1334 Ocean Parkway 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1, ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify:White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Balt Co Bd of Ed. teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Irene Sailor Elmon F Veader 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health an Important: If Item 27 is n any Injury or other traun once. 1334 Ocean Parkway Berlin MD 21811 <u>Elizabeth Veader wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4/2009 Cape Henlopen Crem. Frankford De. 22. Name and Address of Facility The Burbage Funeral Home 21. Signatury of Funeral Service Licensee 108 William St Berlin, MD 21811 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Collibs **Physician** diff. disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-tran Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 236-30-5009 Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

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State Registrar Zeeshan th, Day, Year)
AUG 0 3 2009

29b. Signature and title of certifier

30. Name and activess of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated.

D0064120

ACH 9733 Healthway Drive Berlin

			For State Registrar	State	of Marylar		artment of F r <i>tificate of</i>		nd Mental H	ygiene Reg. No. 🤈 🎧	00	26220
			1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath Day	Voor	3. Time of Death
	Physici /Medio		Sabra Farwell V	oolley					August	t 01, 200	9°"	8:12 P M
	Examin		4a. Facility Name (If not institution, Casey House	give street and n	umber)		4b. City, Town, o		Death	4c. County of Montgo		
	Funeral Director		5. Social Security Number 060–38–6084	.Sex 1 □ M 2 🛣 F	7. Age (In yrs.	last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hours I	Hrs. 8. Date of B Min. (Month, L Apr.	Day, Year)	Cour	place (State or Foreign htry) York
	and w		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation			· · · · · · ·	1	0d. Inside City Limits
	/aryla	ō										1 XYes 2 ☐ No
	the N	Director	MD Montgon  10e. Street and Number	ery	ROC	kville	10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	h with	a D	304 New Mark Esp	lanade			20850			USA		
36	be filed within 72 hours after death with the Maryland ttal Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Modical Evantinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 █ Divorced	Armed F	2 <b>∑</b> No iive		Was Decedent of H If Yes, specify Cub 1 □Yes 2 【 <b>X</b> o	Hispanic Origin an, Mexican, P Specify:	n? (Specify Yes or N Puerto Rican, etc.)	No- 14. Race Black Specify:	, White,	
9	atura		15. Decedent's		Jaics.	16a. Dece	dent's Usual Occup	oation		16b. Kind of Bus		
21215-0036	within 72 iene. • than "ni	Completed	(Specify only highest Elementary/Secondary (0-12)		) (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	f working			
	e filed withir al Hygiene. other than vent, the M	Con		5.	+	Anthr	opologis			Federal		ernment
pu	be file	Be	17. Father's Name (First, Middle, La	*				1		le, Maiden Surname -	e)	
r <u></u>		၉	Douglas Farwell			1 40 44 3		_	nine Adams		24-1	0.40
, Maryland	nd 2 sulth ar		19a. Informant's Name/Relationshi Carolyn Thayer/f							ber, City or Town, S evy Chase		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3				esition (Name of matory or other plan		Date 08/04/09	20c. Location - 0	•	
altir	그 든 쁜 글		4 ☐ Donation 5 ☐ Other (Special Service Li		1 1 11	77 100000				ice P.O.	_	
ä	permi Depar Impo any ir once.	1 2	Beverly L.	Helite	- MC							, MD 21029
			23a. Part 1. Enter the deease, or c shock, or heart failure. List or	omplications that	caused the dea		_					Approximate Interval Between
The same	Physician	r Y	Immediate Cause (Final disease or condition	-	Cancer							Onset and Death
-	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						
3		e	Sequentially list conditions, if any, leading to immediate	b	(or as a consec	quence of):					-	
	tuted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,						
o,	ficate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to	(or as a consec	quence of):						
68760,	ate b	edical		d								
O. Box 6	that the death certific ned by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live	utcome of pregn birth 2 Feta gnant at time of known	al death 3[	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		23d. Date Mor		ery Day Year
α.	that the		Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	d tobacco use contri	bute to t	he cause of death?
Vital Records,	The law requires that ate has been signed b page 2 should be deta	ed by							1	Yes 2□No	3□ Prol	bably 4 Unknown
ဝင္ပင	e law re has be e 2 sho	Completed					_		24a. Wa		ere auto	ppsy findings available impletion of cause of
<u>~</u>	: The l cate ha	Соп							pei 1 □ Yes	formed? d	eath?	2 □No
Vita	Physician: The rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			041		f Death (Check only			
of	ding Physician: In. After this certifica funeral director, p	<u>۲.</u>	1 ☐ Yes 2X No  27. Manner of Death	1	Inpatient 2	ER/Outpatie	III 3 LI DOA			sidence 6 💆 Othe		hospice
o	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investiga	(Mo	nth, Day, Year)	Injury	Wor	rk? ]Yes 2 □ No		e now injury occurre	, u	
Division of	Attending or death. ector After by the fune	ertification:	3 ☐ Suicide 6 ☐ Could no determin	t be 28e. Plac	e of Injury - At h	lome, farm, str	reet, factory, office		28f. Location	(Street and Number own, State)	er or Rur	al Route Number,
ä	tal or rs afte al Dir led n	O	4 - Homicide	Dulli	allig, etc. (Speci	y)			City of T	own, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director A completely filled in by the fu	edical	29a. Certifier (Check only one)  (Check only one)  (Check only one)	caminer: On the	ne best of my kn basis of examin nner stated.	owledge, deat ation and/or ir	th occurred at the to exestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time	ne cause(s) and ma e, date and place, a	nner as : ind due t	stated. o the cause(s)
	<b>То th</b> withir сотр	Me	29b. Signature and title of certifier  JUDIEL	-el o i	.00		29c. Licens		9	29d. Date signed	*	
	$\bigcirc$		J. Koulet	env u	, , , , ,	1)	DE	,3747	0	August 3	, 20	09
	(3)00		30. Name and address of person w Jocelyne Kouatch	no completed cau	use of death (Ite 6001 N	<sup>m 23a) (Type,</sup> <b>luncast</b>	er Mill	Rd. Roc	ckville,	MD 20855		
b	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 4	2009 32.	Registrar's Sign	ature.	arkel					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** OIAM Mary E. Watson JULY 30 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince Georges Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 94 Director 579-26-7995 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evant har roust be notified at Yes 2 □ No Director MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11800 Blanding Court 20720 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after □Yes 217 No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Black 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Staffing Assistant Federal Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental I h and Mental ပ Robert Duckett Charity Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sliment of Health an tant: If item 27 is 11800 Blanding Court Bowie, Maryland 207 Frances Sykes (Daughter) Bowie, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department c Important: If any Injury or once. Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Ft. Lincoln Cem. 08-06-2009 Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ralph Williams, II Funeral Service, P.A. 5202 Princetons Delight Dr. Bowie MD20720 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner ncephalo if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last was dially list out this as Examiner Due to (or as a consequence of) and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 TNo the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ finknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

(Check only 29b. Signature and title of

ELizabeth

TASIKA 8118 Gold Luck

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MAD 609

LANGAM

29d. Date signed (Month, Day, Year) 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician Nancy V. Webb 28 2009 1:56 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll County 3707 Altondale Road Reisterstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/15/1909 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 99 Director 214-12-4605 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Hedical Exx.is et intel to notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Reisterstown 1 ☐Yes 2 No Director MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21136 3707 Altondale Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ⅓ If Yes, Give Year or Dates: 2 **N**No 1 Never Married 2 Married 1 ☐Yes 2 ☐ No Specify: white Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Rosewood State Hospital dietitian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Barber Lillian Taylor ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Baltimore Blvd., Finksburg, Md. 21048 Virginia Sykes, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2009 Finksburg, Md. Evergreen Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility M00741 Eline Funeral Home 934 S. Main Street, Hampstead, Md. 21074 semme 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and tiely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Month Day Year 4 Pregnant Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 2 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \sum\_{\text{Nursing Home}} \) 2 12 No 1 Tes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 D Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

within 24 hours after dear To the Funeral Directo Completely filled in by the within 2 the 0 NJL

> State Registrar

Medical

29a, Certifier

29b. Signa

30. Name and

address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mon

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 3:40 A M July Janet R. Willoughby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 1115 Falmouth Road Waldorf If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 X F Yrs. West Virginia March 10. 1942 Director 67 253-64-7819 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2X No Director Myrtle Beach Horry 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 29588 Funeral 705 Indian Wood L Was Decedent Ever in U.S. Armed Forces?

1 □Yes 2 N No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 72 hours after 1 Tes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 □Yes 2 🛣 No Specify: 2 Specify: 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government : 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 Guv Robert Phillips Virginia Lucille Bolen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Bowie Dr. #908, Baytown, Texas, 77520 Jody Speer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/01/2009 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 21. Signature of Funeral Service Lensee 22. Name and Address of Facility 3035 Old Washington Road Waldorf, Maryland 20601 Huntt Funeral Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MASSALI disease or condition resulting in death) / /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Vear 5 ☐ Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 si autopsy performed? Physician: The After this certificate funeral director, page 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Jy 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 ☐ Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier f 📭 🏗 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

DB 1/2

and address of per-

Year)

AUG 0 4 2009

121

31. Date filed (Month, Day,

completed cause of death (Item 23a) (Type) Print

legistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

		State Registrar     Decedent's Name (First, Middle, Las	t)		ertificate of	Dealli	2. Date of Dea		3. Time of Death
Physic		George Sprink	le Willi	Lams			July	Day Ye 31, 20	
/Medi Examii		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	-	4c. County of D	
		Berlin Nursin	g Home		Berlin			Worces	ter
Funeral		Social Security Number     6. Security Number	7. Ag	ge (In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9.	Birthplace (State or Forei Country)
Director		213-28-7506	AM 2LIF 7	9 Yrs.			11-20-	1929 V	A
ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limit
e Ma 3a-f s tiffied	Director	MDWorcest	er	Berlin					1 <b>X</b> Yes 2 □ N
ith th or 28	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	t Country?
ath w 23a ust b	<u>a</u>	9715 Healthway	Drive		21811			U.S.A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, Ita Medical Examiner must be notified at page.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1▼ Yes 2 ☐ If Yes, Give Year or Dates.	Ever in U.S. No Army 1950 – 54	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣No		pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	American Indian, /hite, etc. ite
72 ho 72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	ı (Giv	edent's Usual Occu e kind of work done	during most of wor	king I	16b. Kind of Busine	ess/Industry
vithin ane. <b>than</b>	dm	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire			Bakery	
Hygie ther in		11 th 17. Father's Name (First, Middle, Last)		Ent	reprene			Maiden Surname)	
2 should be filed and Mental Hygi is marked other aumatic event, II	Be	Robert Willia	me			Nunie	•	maraon barramo,	
hould Me mark	은	19a. Informant's Name/Relationship (7		10h Ma	ling Address (Stree			r, City or Town, Sta	te Zin Code)
id 2 s lith ar 27 is trau					•				ty, 21842
s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Debbie Byrd/Dau 20a. Method of Disposition	gircer	20b. Place of Dis	position (Name of ematory or other pla	Truge K	Date	20c. Location - City	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		ematory or other <b>g</b> ig Cremato		-2009 <sub>[</sub>	over, D	F
permit. Pag Department Important: I any injury o		21. Signatur, of Fun			22. Name and Addr. Bennie S			Isabell	
and de la	-	MO	feel ) E		Bennie S Funeral	Mith Home		ry, MD	
Physician /Medical Examiner as the prival-transit as the burial-transit	edical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):  a consequence of):  a consequence of):	MENTIF		- 1-0		
as ∰	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	B	су		23d. Date of Month	f delivery Day Year
gned by	þ	Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying cause gi	ven in Part I.			te to the cause of death?
uire Id b	olete						24a. Was autop	sv prio	
an: The law requires titicate has been signor, page 2 should be	e Completed	25. Was case referred to finedical				26 Place of De		ne)	
ending Physician: The law requires tath.  The function of the	Be	27. Manney of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ient 2 □ ER/Outpati ury 28b. Time ay, Year) Injury	of 28c. Inju	her: 4 Nursing H	ath <i>(Che</i> ck o <i>nly</i> o	ne) dence 6 ⊡ Other ( now injury occurred	
ath. r: After this	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Inj (Month, Date of Inj (Both Date of Inj (Both Date of Inj building, el	ury 28b. Time Injury 28b. At home, farm, stc. (Specify)	of 28c. Inju Wo 1 Estreet, factory, office	her: 4	ath (Check only only only only only only only only	dence 6 □Other ( now injury occurred Street and Number on, State)	Specify) or Rural Route Number,
Hospital or Attending Physician: The law require 24 hours after death. Pruneral Director: After this certificate has been signified in by the funeral director, page 2 should b	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Uertifying Ph	28a. Date of Inju (Month, Da 28e. Place of Inju building, el	ury ay, Year) 28b. Time Injury  jury - At home, farm, stc. (Specify)  of my knowledge, de of examination and/or	of 28c. Inju M 1 E	her: 4	ath (Check only on the check on the	dence 6 □Other (now injury occurred street and Number of the street)	Specify) or Rural Route Number, er as stated.
To the Hospital or Attending Physician: The law require within 24 hours after death.  The Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should b	Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Exam	28a. Date of Inju (Month, De  28e. Place of Inju building, el  ysician: To the best	ury ay, Year) 28b. Time Injury  jury - At home, farm, stc. (Specify)  of my knowledge, de of examination and/or	of 28c. Inju M 1 E street, factory, office ath occurred at the investigation, in my	her: 4	ath (Check only only only only only only only only	dence 6 □Other (now injury occurred street and Number of the street)	or Rural Route Number, er as stated. due to the cause(s)
To the Hospital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: After this certificate has been significant to the Funeral Director, page 2 should be a	Certification: To Be	examiner?  1 Yes 2 No  27. Manner/of Death  1 Matural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Vertifying Phylone	28a. Date of Injuice (Month, Date of Injuice) 28e. Place of Injuice of Injuic	ury - At home, farm, stc. (Specify)  of my knowledge, de of examination and/or tated.	of 28c. Inju Wo 1 Estreet, factory, office ath occurred at the investigation, in my	her: 4 Nursing	ath (Check only only only only only only only only	dence 6 Other (now injury occurred street and Number of the form, State)  cause(s) and mannidate and place, and	Specify) or Rural Route Number, er as stated, due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 21 per DVR G894 8/17/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay **Physician** 200°9 August 6:15 Ам Colleen L. Wolfe /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A 729 W 34th Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) 66 Months Days Hours 1 □ M 2X13X F Director 215-42-8469 Feb. 14 1943 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Menlar Hygiene. Important: If them 27 is anarked other than "natural", or items 23a or any Injury or other traumatic event, Itan Marical Excultion mast bor any Injury or other traumatic event, Itan Marical Excultion mast Bor 21211 USA 729 W 34th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White þ Yes Give 1 ☐ Yes 2X No Specify Specify. 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Worker CSX Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Swain Howard Broyles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 W 34th Street, Baltimore MD 21211 Hope Johnson Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/2009 Sykesville, MD Lakeview Memorial 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home 21. Signature of Funeral Service Licensee Lynn B. Henss per DVR 3631 Falls Road, Baltimore MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alcoholic Cirrhosis Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ng physician and as the burlal-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 cate has been si page 2 should t 1 ☐ Yes 2 Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 □No 1 ☐ Yes 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1∐ Yes 2XIXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 🔯 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573

State

Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey C. Zibell, MD

Acked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Month **Physician** edward. Lindberge Yonker, Jr. 2009 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Iniversity of Mayland Med. Center Baltimore City Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 √ M 2 □ F Months Days Hours Min. 212-24-0947 81 Yrs Director MD Aug. 08, 1927 Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits or Items 23a or 28a-f show event, the Medical Examinar - ust be notified at Director 1 ☐ Yes 2 📉 No MD Allegany Little Orleans 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11306 Stottlemyer Road 21766 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No þ Specify: Specify: Hygiene. other than "natural", 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Retail Manufacture Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the any Injury or other traumatic event, Insupose. Self-employed Sales Mobile Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Edward Lindberge Younker, Sr. Maye Carnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilda J. Yonker/Wife 11306 Stottlemyer Road Little Orleans, MD 21766 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Piney Plains U.M.Cem. 08/08/2009 Little Orleans,MD 21. Sk nature of Funeral School 22. Name and Address of Facility 141 West Main Street Mcoze Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Left MCA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform orcine adric valve 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be deteched for use as the burlat-transit Division of Vital Records, P.O. Box 68760. To the Hospital of within 24 hours at To the Funeral D completely

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

29b. Signature and title of certifier a M Pritchard MD 29c. License number 29d. Date signed (Month, Day, Year)

11346405735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street, Baltimore, MD chard 32. Registrar's Signature

State Registrar

Medical

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3

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	otato ot mo	,, _	Certificate of	Death	R	eg. No. 201	19	262	35
		1. Decedent's Name (First, Middle, L	.ast)				2. Date of Deat			. Time of D	
Physi /Med		Ira	Gilbert 2	Zepp, J	r.		August	1, 20°	09 7	7:37	Ам
Exam		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of			
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Funera Directo		5. Social Security Number  215-24-6252  Usual Residence of Decedent	Sex 7. Age	79	rs. Months Days			1929	Mary]		
land		10a. State 10b. County		10c. City, Town	or Location				10d.	Inside City	Limits
Mary -fsh	to	MD Carro	011	West	minster					1 ∐ Yes 2	2 ☑No
n the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	-	)	
th wit	Funeral Director	576 Marshall	l Drive		2115	57		U.S.A	•		
r dea	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of I	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American I White, etc.	Indian,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example at interparations.	d by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 📆 N If Yes, Give Year or Dates:	0	1 ∐Yes 2∭XNo	Specify:			White		
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ary shou and M	-	19a. Informant's Name/Relationship			Mailing Address (Stree	t and Number or R	ural Route Number	r, City or Town, St	tate, Zip Co	de)	
ind 2 alth a saith a 27 is		Mary E. Zepp	- wife	57	6 Marshal	ll Dr. V	Vestmins	ster, M	D 21	1157	
of He		20a. Method of Disposition	□ B	20b. Place of cemeter)	Disposition (Name of crematory or other pla	nce) 08/0	372009	20c. Location - Ci	ity or Town,	State	
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m gora		Justi K.	July		•		Westmir			2115	
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spital spurs neral filled		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge	death occurred at the	time, date and plac	ce, and due to the	cause(s) and man	ner as state	ed.	
Division  To the Hospital or Attent within 24 hours after deatt To the Funeral Director; completely filled in by the	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	examination and ted.	d/or investigation, in my	opinion, death occ	curred at the time, o	date and place, ar	nd due to the	e cause(s)	
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WJL		Horway	MUL	LNJ	13	5514	- 1	04 -C	)3 -	20	UP
5		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (	Type, Print)	,					
		- laviohautor	512 Du	thea	Type, Print) Lov Stree	t Wast	INSTER,	H1)2115	7		
S Regis	tate trar	31. Date filed (Month, Day, Year)		r's Signature	1						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marjorie 2009 Edythe Allsop 2:15 pM Aug. 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore 8. Date of Birth (Month, Day, Ye Sept. 29 Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) 6. Sex (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 058-14-1552 Sept. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examination will be inclined at MD Freeland 1 ☐ Yes 2 ☑ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Baker Schoolhouse Road 21053 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black Specify à 3 d Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12th Retirement Specialist NYC Retire. System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAYMOND JAMES HELENA WILSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Gayle Doak - Daughter Baker Schoolhouse Rd Freeland MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State AUGUST 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. 8-22-09 4 □ Pontation 5 □ Other (Specify) Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March Funeral 4300 Wabash Ave Home West Balto. MD 21215 23a. Partit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) END STAGE RENAL DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) y physician and stranger tranger Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALLSOP þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has MARJORIE autopsy The perform certificate 2X No 2 No 1 ☐ Yes 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifier

(Check only one) X Nurse Practitions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) X Nurse Practitions The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) X Nurse Practitions The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical

State

29b. Signature and title off certif

30. Name and address fr

MARIAM \_\_\_\_\_31. Date filed (Month, Day, Y MARIAM BAKIK,

Registrar

2300 DULANEY VALLEY RD.

on who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

CRNP

Yea 8

29c. License number

0

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 4 U U J Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:45 PM JAMES, ADAMS 2000 16 /Medical 4a. Facility Name (If not institution, give street and number) UMMC 4c. County of Death 4b. City. Town, or Location of Death Examiner 22. S. Greens 3+ Baltimor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 1 XM 2 □ F Months Hours MARCH 11, 1949 MD 60 Director 214-50-5758 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfort Example of the resolution once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 AYes 2 No Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 USA 4369 OLD FREDERICK RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 No If Yes, Give Year or Dates: 1969–71 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 🛣 No Specify: Specify BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GENERAL MOTORS DRIVER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CATHERINE BUTLER LAYFIELD ADAMS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21229 4369 OLD FREDERICK RD. BALTIMORE, MD GRACE N. ADAMS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST CEM. OWINGS MILLS, MD 8-24-2009 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 21217 1701-31 LAURENS ST. BALTIMORE, MD mortoni ames 23a. Part 1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to or as a consequence of): Examiner Liver Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical as the IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? Attending Physician: The law 24a. Was an has autopsy performed certificate 2 No 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature applitte of Certifier 29d. Date signed (Month, Day, Year) 29c. License number P22955 AUCKUST 16,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GANESM S. Greens 22 SA Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5:30 PM , 2009 AUGU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RANUSTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Min. 220-54-7178 SEPTEMBER 4,1852 Director AROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 □ No BALTIMORE Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 5. A AVENUE CRANSTON Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: à Specify: TRIACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Charles NUSINOV+Sons 2WELER YEAR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES BROWN MARY ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 3818 CRANSTON AVE., BALTIMORE, MD 21229 (SISTER) MARJORIE BROWN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 08/13/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
SOSEPH H. BROWN JR. FUNERAL HOME
2440 N. FULTON ANE, BALTIMORE, MD 21917 21. Signature of Funeral Service Licenses illiamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SICICLE 251 DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a P.0. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 Yes 2 No 3 Probably 4 Nown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐Yes 2 🔼 No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending T⊠ Natural 5 Pending investigation ours after death.

neral Director; A
filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a **To the Funeral I**completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061765

State
Registrar

TBONE OF N.
31. Date filed (Month, Day, Year)
AUG 18

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sales

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 17 Day **Physician** 2009 7:50 Ам August Joseph Glenn Blackburn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Essex 1834 Kittyhawk Rd. Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 22, 1927 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F North Carolina 202 16 8830 Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natified at once. 23a or 28a-f show Baltimore Essex 1 ☐Yes 2X No Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 1834 Kittyhawk Rd. USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 White 1 □Yes 2X No Specify: Ś 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 3 17. Father's Name (First, Middle, Last)
Joe Blackburn 18. Mother's Name (First, Middle, Maiden Surname) Be Bertie Elvira Vannoy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Violet May Blackburn (Wife) 1834 Kittyhawk Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/2009 Baltimore, Maryland Dak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service sicensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
204104 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Phyaiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performe 2 🛛 No 1 ☐Yes 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1∐Yes 2XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐No neral Director: A 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier ည

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

8

Registrar's Signature

			For State Registrar		State of IVI	aryland .		rtificate of	nealth and r <i>Death</i>		eg. No.		Taskey And Comment
	Physici	an		e (First, Middle, Last,	)					2. Date of Deat Month	th Day	Year	3. Time of Death
100	/Medi				Yvonne		Ba	ailey		8 1	1 20	09	6:57 a M
	Examir	ner		f not institution, give		)		4b. City, Town, o	or Location of Death	1	4c. County	of Death	
		-	5. Social Security No	s Nursi		ge (In yrs. last	hirthday)	Dunda If Under 1 Year	k If Under 24 Hrs.	8. Date of Birth			place (State or Foreign
	Funeral Director		245-26- Usual Residence of	-0971 <sup>10</sup>	М 2 🔀 Г	86	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) -1923	Coul	N.C.
	/land low		10a. State	10b. County		10c. City, T	own or Lo	cation				1	10d. Inside City Limits
	Mary a-f sh	향	MD	Ва	lto	Dun	dalk						1 □Yes <b>2</b> 1□ No
	or 28	ire	10e. Street and Num	nber				10f, Zip Code		1	0g. Citizen of V		ntry?
	23a	2	7232 Ge	rman Hil	.1 Road				21222		Ü	S A	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the flection Event incomment to notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed	unk led 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	)		Was Decedent of I f Yes, specify Cub I □Yes 2 🙀 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		k, White,	can Indian, etc. Lack
5-0	72 ho	eted	(Special	15. Decedent's Edu ify only highest grad	cation	1	6a. Dece	dent's Usual Occup	pation	kina	16b. Kind of Bu	usiness/In	dustry
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anc	uld be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (	FIFST, Middle, Last)	unk				18. Mother's Nam	ie (First, Middle, I	viaigeri Surriari	re) [	ınk
Maryland	2 should and Mer Is marke	မ	10a Informant's Na	ame/Relationship (Ty	vna Print)	-1	10h Mailir	ng Addross (Stragt	t and Number or Ru	ral Pouta Number	r. City or Town	State Zir	o Code) 21202
Ma	nd 2 s Ith ar 27 is r trau			Linton-		117			vert Str				
ā,	thealth tem 27 other to		20a. Method of Disp		guarare			sition (Name of natory or other pla			20c. Location -		
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.			☐ Cremation 3 ☐ F 5 ☐ Other (Specify)		1	-		ery 8-1	7-2009	Balt	imar	
i i	permit. F Departm Importar any inju	l iii		neral Service Licens		1110	4	. Name and Addre		larch Ea			e MD
ä	permi Depar Impo any ir	1. 18	► B	lady	war	-	_   1	.101 E.	North A				21202
			23a. Part 1. Enter th	ne disease, or compl rt failure. List only or	ications that cause	d the death. [	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arm	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (I disease or condition resulting in death)	Final	Due to (or as	EROS a consequen	S C L ce of):	EROTI	I CAR	DIOVASO	WLAR	DI	Onset and Death
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1/	ed sit	Examiner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or ithat initiated events	mediate rlying	Due to (or as	a consequen	ce of):	EMIA					
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68760,	rificate be executed ng physician and as the burial-transit	edical			d								
O. Box	Physician: The law requires that the death certi this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnand Other <i>(specify)</i>	су	<del> </del>		te of deliv onth	very Day Year
о. С.	that ned b deta	by Pr	Part II. Other signifi	icant conditions col	ntributing to death b	out not resultin	g in the ur	nderlying cause giv	ven in Part I.	23e. Did tol	bacco use cont	ribute to t	he cause of death?
rds	quires an sig uld be	g p	<u> </u>							1 □ Y€	es 2□No	3□ Pro	bably 4 Onknown
Records,	he law reite has bee	Completed								24a. Was a autops perform	med?	prior to co death?	opsy findings available ompletion of cause of
of Vital	ysician: The iis certificate h director, page	a	25. Was case referre	ed to medical					26. Place of Dear	1 □Yes th (Check only on		1 □Yes	2 <b>D</b> Mo
<b>f</b> <	nysici nis ce direc	9 0	examiner? 1 ☐ Yes 2 ☐	No F	lospital: 1 ☐ Inpati	ent 2□ER	/Outpatien	t 3 DOA Oth	nor:	ome 5 ☐ Reside		er (Speci	ify)
0 U	ding Ph h. After thi funeral	ü	27. Manne Death	n 5 ☐ Pending	28a. Date of Inju	ury 28	b. Time of Injury	28c. Inju Woi		28d. Describe ho			
Sio	endii eath. or: A the fu	atic	1 Accident	investigation					]Yes 2□No				
Division	or Att after d Direct in by	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of In building, e	jury - At home tc. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Numb n, State)	er or Run	al Route Number,
_	To the Hospital or Attending Powithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Co	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami	ner: On the basis of	of evamination	and/or in	vectigation in my	oninion death occu	rred at the time d	late and place	and due t	to the cause(s)
	To the virthing of the complex	Me	29b. Signature and t	title of certifier				29c. Licens	se number	2	9d. Date signe	d (Month,	Day, Year)
			1 Sa	inde	1 Jul	elle M	10	D:	2718	8	8-12	2-E	9
			30. Name and addre	ess of person who co	empleted cause of a	death (Item 23	sa) (Type,	+ Place	e Dun	1dalle	MD	2,	Day, Year)  9  1222
	Sta		31. Date filed (Monti	h, Day, Year)	32. Regist	rar's Signature	1 1	arker	***				
	Registr	ar		AUG 18 20	109 Sens	un p	19						

			- For Amend Item Registrar	23a per	Maryland dr.,g8	94,08/ Ce	utment 18/09 rtificate	of H dhb of L	ealth Death	and Me	ntal Hy	giene Reg. No	2009	26241
			1. Decedent's Name (First, Middle, La								Date of Dea			3. Time of Death
	Physici: /Medic		Sheree Beksins	ĸi						Αι	ıgust			4:30A <sup>™</sup>
	Examin		4a. Facility Name (If not institution, gi	e street and nun	nber)		4b. City, 7	lown, or	Location	of Death		4c	. County of Dea	
	-		1216 Basil Cou						l Air				Harf	
	Funeral		5. Social Security Number 6. 8	Sex 1□M 2□F	7. Age (In yrs. la	ast birthday) Yrs.	If Under	Days	If Under Hours	Min.	Month, Da	ı <i>v. Year)</i>	C	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		53_	113.				A	oril 2	4.1	956	MD
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary -fsh	후	Md. Ha	rford			Bel A	ir						1 □Yes X□No
	r 28a	Director	10e. Street and Number	LIOLU			10f. Zip					10g. Ci	tizen of What C	ountry?
	h witl		1216 Basil Cour	t				210	14				USA	
	dear ems	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S	3. 13.	Was Decede	ent of Hi	spanic Or	igin? (Speci n, Puerto Ric	y Yes or No	-	14. Race - Am Black, Whit	
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7	n 72	lete	15. Decedent's E (Specify only highest gr	ade completed)	17	(Give	dent's Usua kind of worl DO NOT use	k done d	luring mos	st of working	- 1	100. 1	and of business	/industry
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<u>lar</u>	Aenta Aenta rked tic ev	To B	George Fazenbake	r					Ruth	Park	er			
ar?	shou and h		19a. Informant's Name/Relationship	(Type. Print)	-	19b. Mailir	ng Address	(Street a	and Numb	er or Rural F	Route Numb	er, City	or Town, State,	Zip Code)
Σ	and 2 ealth n 27 i		Edward D. Beksin	ski (Hus	band)	1216	Basil	Ct	Be1	Air, l	MD 210			
ore	es 1		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 E	Removal from S	1 0	ace of Dispo emetery, crer	sition (Nam natory or ot	e of her place		Date		20c. L	ocation - City or	Town, State
Ë	Pag ment tant:		4 □ Donation 5 □ Other (Speci	fy)	Bay	view (		_	1	08-07-			ltimore	
Baltimore. Marvland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Important: If fire X7 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examination is used the notified at once.		21. Signature of meral S. vice	nsot 2									eral Ho ir, MD	me of BelAir
		$\vdash$	23a. Pert1. Enter the disease, or con	nolications that ca	used the death				-				II, FID	Approximate Interval Between
13	Discolation		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ich line. Ca:	rdiopu	lmona	ry A	rres	t	m # 12	.,,		Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (	cras a consequ	-	1378	-001		1111	9/11		-	
	Examiner					ltiple	Syst	em A	trop	hy				
2		ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (	or as a consequ	erice of).				_				
11/6	and Iransi	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
, o	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ä	resulting in death) Last	Due to (	or as a consequ	ence of):								
,8760.	cate t	dical		<b>d</b>										
မ	eath certific attending p	/Me	IF FEMALE:	23c if was out	come of pregnar	ncv							20d D-4- 44d	li
Box	atten for us	ian	23b. Wes decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 Fetal	death 3 [	Ectopic pr		/			ĺ	23d. Date of de Month	Day Year
P.O.	at the de by the tached	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unkno		Suui J	Jotner (sp							
	that hed b		Part il. Other significant conditions	contributing to de	ath but not resu	Iting in the u	nderlying ca	use give	en in Part	l.	23e. Did t	obacco	use contribute	o the cause of death?
Records.	juires n sign ild be	d by									10	Yes 2	2 <b>□</b> LNO 3 □ F	Probably 4 Unknown
ဝ	aw require s been si should b	Completed									24a. Was		24b. Were a	utopsy findings available
	The law cate has page 2 s	mo W									autor perfo 1 ☑ Yes	rmed?	death?	completion of cause of
⊘ <b>t</b>	an: antifica	o l	25. Was case referred to medical						26. Płac	e of Death (			oj ilite	\$ 21140
કુ≥	Physician: The trins certificate Ir ai director, page	To B	examiner? 1 ☐ Yes 2 ☑ 1√0	Hospital: 1 🗆 I	npatient 2 🗆 I	ER/Outpatier	nt 3 DO	A Othe	25.				6 ☐Other (Sp	ecify)
T - Modes	ding Ph h. After th funerai	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day, Year)	28b. Time o Injury	f 28	Bc. Injury Work	y at	28	d. Describe	how inju	iry occurred	
Sio	vttendi death. ctor: A y the fu	catio	2 Accident investigation 3 Suicide 6 Could not to				М		Yes 2□					
	0 # 5 -	Certification:	4 Homicide determined	28e. Place buildir	of Injury - At ho ng, etc. <i>(Specif</i> y	me, farm, str	eet, factory,	office		28	f. Location (: City or To	Street a wn, Stat	nd Number or F le)	Rural Route Number,
6	Hospitai 24 hours a Funeral I		29a. Certifier 1 Certifying P											
10	the Ho hin 24 the Fu mpletel	Medical	(Check only 2 Medical Exa	miner: On the ba		tion and/or in				ath occurred	at the time,			
	To Vit	2	29b. Signature and title of certifier						e number	7 2		29d. Da	ate signed (Mor	ith, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print).  STEPHEN 6 REICH WI) UNIVERS & MORY COUNTY NEW NOOFY											
_	Oj		30. Name and address of person who	EICH	W()		Print)	35	Ma	rylan	DA	1/ce	1209	7
	Sta Registr	te ar	31. Date filed (Month, Day, Year) AUG 18 20	09 De	egistrar's Signat	. fa	Med	O		•				

09-06309 Charles Bradley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 26242

		For State		-		Certific	cate of	Death					Reg. No.	Com 1			Code C
Physicia		. Decedent's Name (First, Mi	idle, Last)									Date of De Month	Day	Year		e of Death 28 hrs	
edical Examir		Charles	М.		dley	I	II					August 1		c. County of I		201110	
		a. Facility Name (if not institu		street and nu	ımber)		4	b. City, Tov		ocation of	Death		\ \frac{1}{3}	N/			
		Johns Hopkins Hos			7 A /Im	yrs. last b	irthdou()	If Under		If Under	24Hrs.	8. Date of E	Birth (MM		9. Birthplace	(State or F	oreign
Funeral		5. Social Security Number 219-75-4608	6. Sex		,	•		Months	Days		Min.			2006	Country)	MD	1
Director				M 2 F	3		Yrs				<u>.                                    </u>						-
*		Usual Residence of Decedent  10a. State 10b. Cour	tv		100	c. City, Tow	n or Locati	on	_							nside City	
OW BI		MD I	Ϊ/A			Ва	ltim	ore							1 🖸	Yes 2	No
yland a-f sh	휘	10e. Street and Number						10f. Zip C	ode				10g. Ci	tizen of What	t Country?		
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	2026 N.	Р	ayson	St	reet		2	121	.7				USA			-
ith th		11. Marital Status		12. Was De			13 Wa	s Decedent	of Hisp	anic Origi	n? (Spe	cify Yes or I	No-		American In	dian, Black	.,
ath w items	uneral		Married	Armed F			If Y	es, specify	Cuban,	Mexican,	Puerto R	lican, etc.)		White,			
her de	ᄔ	3 Widowed 4	Divorced	If Yes, Give Ye			1	Yes 2X						Specif <b>B</b> 1			
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. **Red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	d b	15. Decedent's Education (	Specify on				a. Deceder	nt's Usual O	ccupati	on (Give k	ind of wo	ork done ed)	16b.	Kind of Busi	ness/Indust	У	
72 hc	Completed	Elementary/Secondary (0-	12)	College (	1-4 or 5+) A		chi							N	I/A		
033 vithin ene.	E C	N/A			-/ A					10 Mothor's	c Name (	First Middle	e Maide	n Surname)			
15-0 iled v Hygi d oth		17. Father's Name (First, Mid	dle, Last)									elle	o, maide	Fall	on	Bak	er
21215-003 uld be filed withi Mental Hygiene. marked other tt	o Be	unknown 19a. Informant's Name/Relati	onshin (T	vne Print )			19b. Mailin	g Address	(Stree				lumber,	City or Town		Code)	
ID 21 should I and Mer 77 is man	ř	Orielle Fa			r-mc			26 N	. F	ays	on S	St. B	alt	imore	e, MD	212	17_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner minjury or other traumatic event, the Medical Examiner minimatic event, the Medical Examiner minimatic event with the minimatic event of the m	ŀ	20a. Method of Disposition				20b. Plac		sition (Name	e of cen	netery,		Date	200	c. Location - 6	City or Town	, State	
lore litoff t: If i		1 X Burial 2 Crema			from State	Kir	ng Me	em. P	ark	ς	8/2]	L/200	9	Randa	allst	own	MD
Itir nit. Pr artmen ortan		4 Donation 5 Othe 21. Signature of Funeral Ser					22.	Name and A	Address	of Facility	MAI	RCH F	UNE	RAL F	HOME-	EAST	
Department	S 5	40.0		1,70	ne		1 1	101	Ε.	Nor	th A	Avenu	e B	altin	nore,	MD	2120
Physician		23a. Part I. Enter the disease failure. List only one ca	, or comp	lications that	caused the	e death. Do	not enter	the mode of	f dying,	such as ca	ardiac or	respiratory	arrest, s	shock, or hea	rt Ap	proximate etween Ons	set and
Medical	8 9	Immediate Cause (Final dise		Multiple B	lunt For	ce Injuri	es									Death	-
taminer		or condition resulting in deal	h)	Due to (or as	a consequ	uence of):									1		
	<u></u>	Sequentially list conditions, if any, leading to immediate	b.,	Due to (or as	a consequ	uence of):											
	nin e	eause. Enter Ut denying Co (Disease or injury that initiat	gge C.														
si. d	Examiner	events resulting in death) L		Due to (or as	a consequ	uence of):									İ		
760, cate be executed physician and the burial - transi		LINDENDED	d.	AMENDE	#1	as no	ted p	er ME	- G8	94 8/	31/0	79 TT					
760, cate be ex physician	Medical	UNPENDED				of pregnar	nev							23d. Date of	delivery		
		IF FEMALE: 23b. Was decedent pregnant	in the		e birth		<sub>2</sub> _ F	etal death	3	Ectopi	c pregna	incy		Month	Day	Y	ear
Box 687 e death certificates at the attending	icia	past 12 months?	Unknowr		-	me of death	5 0	Other (Spec	cify)				- 1				ĺ
Bo ne dea the a	Physician	Part II. Other significant co		9 011	cnown	out not resu	ulting in the	underlying	cause	given in P	art I.	23e. D	oid tobac	co use contri	bute to the	cause of de	eath?
i, P.O. B ires that the d signed by the	by	Part II. Other significant co	illullions	CONTIDUCTIO	, to death i	out not rest	aiting in the			<b>J</b>		1	Yes 2	2 V No 3	Probably	4 Un	ıknown
S, F quires en sig	ted	// <del></del>											Vas an	24b. V	Were autops	y findings	available
ords, aw requir nas been s 2 should l	ompleted						<del></del>					p	utopsy erforme	<u>d</u> ? (	orior to comp death?		_
Rec The I	Sol								00 Di	f D - e4h	(Cheek		es 2	No 1	<b>✓</b> Yes	2	No
of Vital Records, P.O. Box 68:  ng Physician: The law requires that the death certifi wher this certificate has been signed by the attending meral director, page 2 should be detached for use as:	Be	25. Was case referred to me examiner?		Hospital: 1	Innation		R/Outpatie		OOA	of Death		ng Home 5	Re	sidence 6	Other:		
F Vit Physic er this ral din	<u>ا</u>	1 ✓ Yes 2 No 27. Manner of Death			ate of Injury		8b. Time o			ury at Wor	_	28d. Desc	ribe how	injury occur	red		
_	Ë	1 Natural 5	Pending	Aug 7	nth Day Ye. , 2009	ar)	1245 hrs		1	Yes 2 🗸	<b>/</b> No	Subject	assau	Ited			
Sior Attend r death ector: by the	cat	2 Accident	Investigat	28e P	lace of Inju	ıry - At hom	ne, farm, st	reet, factory	, office	building, 6	etc.	28f. Locati	ion (Stre	et and Numb	er or Rural	Route Num	ber, City
Division  Division  To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: V completely filled in by the ft	Certification:	3 Suicide 6 4 Homicide	Could not determine	i be		le Famil						8273 Ton	wn, State	e) Court , Seve	rn , MD		
lospit 4 hour funer ely fill		29a, Certifier	ng Physic	ion. To the	boot of my	knowledge	death occ	curred at the	e time, o	date and p	lace, and	d due to the	cause(s	) and manne	r as stated.	( )	
To the Hos within 24 h	Medical	(Check only 1 Certify one) 2 Medica	Examine	er:On the bas	is of exam	ination and	d/or investig	gation, in m	y opinio	on, death o	ccurred	at the time,	date and	g place, and c	due to the C		
	Me	29b. Signature and title of o	ertifier					29		se numbe	er			9d. Date sign		Day, Year)	
		ane 22							0.0	.M.E.				August 14	, 2009		
		30. Name and address of p					23a)	<u> </u>	D - !!!		3 0400	11					
		Ana Rubio MD.		ant Medica				Street,		ndre, ML	2120						
	State		rear)	000	. Registrar	's Signature	h h	arke	/								
Regi		AUG	107	<del>1113 /</del>	15 16 66		ORIGIN	IAL									
DHMH 17 Rev 1.	2001			OCAM			OKIGIN	1/1/									

		State 0	of Maryland	•	ertment of H Stificate of L	lealth and N Death		iene <sub>eg. No.</sub> 20	09	26243
Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month AUGUS	h Day	¥2009	3. Time of Death
/Medic			nett			1	HUGUS			
Examin	er	4a. Facility Name (If not institution, give street and nu Saint Joseph Medic	cal Cen	ter	4b. City, Town, or	Location of Death	on	4c. County	Balt	imore
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2XXF	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/12/19	Year) 930	9. Birthplac Country Indian	ce (State or Foreign y) 1a
pun 🔥		Usual Residence of Decedent  10a. State 10b. County		Town or Lo	cation		-	·	10d	I. Inside City Limits
Maryla f sho	lor	2 -	,	rdeen						1 <b>X</b> Yes 2□No
r 28a	irec	MD Hartord  10e. Street and Number	ADE	Luceii	10f. Zip Code		1	0g. Citizen of V	Vhat Country	y?
th with	ral D	147 Rigdon Road			210	01		U.S.A.		
er dea	nue	Armed Fo	edent Ever in U.S. orces?	13. \	Nas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americar k, White, etc	
irs afte	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or D	ive		l∐Yes ·2 <b>⊠</b> No	Specify:		Specify	Whit	:e
72 hou	ted	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	dent's Usual Occup	ation	ing.	16b. Kind of Bu	usiness/Indu	stry
rithin 7 ne. han "r	mple	Elementary/Secondary (0-12) College (			kind of work done o					-1
iled w Hygie ther ti nt, th		12 2 17. Father's Name (First, Middle, Last)		Test	Specialia	ST 18. Mother's Nam		J.S. GOY		int
should be filed within 72 hours after death with the Maryland und Mental Hygiene. In the Maryland in a marked other than "natural", or items 23a or 28a-f show umatic event, the Marical Evanting in the notified at	To Be	Allen Holt					n Barbe		-,	
shou and N s mar		19a. Informant's Name/Relationship (Type. Print)			ng Address (Street					ode)
and 2 tealth m 27 her tra		Freddy Bennett (Spou			Rigdon R		erdeen, M			0
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Inpopratment of Health and Mental Hygiene. Inpoprant, if them 27 is marked other than "instural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination with any once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	State		sition (Name of natory or other plac	i .		20c. Location -	•	
nit. Perantme  ortant  injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Vete		Mem. Ceme		/09 M	<u>Madison</u>	, Indi	ana
Dep Dep onc		NII Alon V M. al 100	26006			Cargo Fun			•	
		23 Part 1. Enter the disease, or convilications that shock, or heart failure. List only one cause on	used the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	11	Approximate nterval Between
Physician			RDIOGEN	IC S	HOCK					Onset and Death
/Medical Examiner		resulting in death)  Due to	(or as a conseque	ence of):	RCT					
10 32	Jer		(or as a conseque							
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
cate be executed physician and the burial-transit		resulting in death) Last Due to	(or as a conseque	ence of):						
	dical	d								
n certif	Physician/Me		tcome of pregnan					23d. Da	te of delivery	4
death he atte	sicia	in the past 12 months? 1 ☐ Live 1 ☐ Yes 2 ☑ No 4 ☐ Prec	birth 2 ☐ Fetal of gnant at time of dea		☐Ectopic pregnanc ☐Other (specify)	У		Mo	onth D	ay Year
at the d by tl	Phy	9 Unknowh  Part II. Other significant conditions contributing to d		ting in the u	adorlying onless give	on in Part I	23a Did tol	hacco use cont	ribute to the	cause of death?
uires ti	d by	Renal Failuse	leath but not result	ing in the di	idenying cause givi	en in i diti.		es 2 No		Aug.
w requ	Completed by	C-oronarii Ar	GOLL	Din	00100		24a. Was a	n 24b.	Were autops	sy findings available
The la	omp		ive y	<i>1) (1)</i>	Eller Co		autops perforr	ned?	prior to comp death? 1 □ Yes 2	pletion of cause of
sertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat			10163 2	
hysic this co		1 Yes 2 No Hospital:	Inpatient 2 □ E			4 □ Nursing H	ome 5 Reside			
ding P. h. After funera	tion:	1 2 Tandard	of Injury oth, Day, Year)	28b. Time of Injury	Work	y at ⟨? Yes 2 □ No	28d. Describe ho	ow injury occuri	red	
Atten r deat ector: by the	ifica	3 Suicide 6 Could not be determined 28e. Place	of Injury - At hom	ne, farm, str		103 2	28f. Location (St		er or Rural I	Route Number,
talor rs afte alDir	Certification: To	4 ☐ Homicide determined build	ling, etc. ( <i>Specify</i> )				City or Town	n, State)		
To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  12 Sertifying Physician: To the 2 Medical Examiner: On the land man	e best of my know basis of examination oner stated.	ledge, deatl on and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occur	, and due to the c red at the time, d	ause(s) and m late and place,	anner as sta and due to t	ited. :he cause(s)
To the within To the complete	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signe	d (Month, Da	ay, Year)
		• //			D	46356		fugus	15	2009
<b>'</b>		30. Name and address of person who completed cau	`	, , , , ,	•				1973	200.0%
Sta	te		D., 76		SLER DR	IVE, TO	VSON, M	HRYLA	AD E1	204
Registr		AUG 18 2009	a A	Jack	Part .					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2009 JohnHazel Brown 08 5:20p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Months Davs Country) Director 72 239-54-7129 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Baltimore MD NA XIX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a o Funeral 21229 U.S.A. 4225 Euclid Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Black 3 ₩ Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than should be filed within 7 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home 9th grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Johnsie Jeffries John Hargrave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. 4225 Euclid Ave, Baltimore, Md 21229 Terry Brown-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 8/24/09 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Baltimore, Md 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 ancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes Yes 2 To the Hospital or Attending Physician: 'within 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

AMUN

31. Date filed (Month, Day, Year)

AUG 18

John

Backe

6701

Registrar's Signature

N. Charles St Yousen MD

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		Cei	rtificate of L	Death	Re	g. No.	009	2621	45
	Dhypini		1. Decedent's Name (First, Middle,	Last)				Date of Death     Month	Day	Year	3. Time of Dea	
	Physici /Medic		Louise	н	Bro	wn		August			2:30 P	, M
4.	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. Co	ounty of Death		
-			Broadmead				ysville			Baltim		
	Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Coun	lace (State or For	-
	Director		165-18-7943	1□M 2 <b>X</b> F	<b>89</b> Yrs.			Dec 1,	1919	Penns	sylvania	1
	pu >		Usual Residence of Decedent		10c. City, Town or Lo	anting				1	0d. Inside City Lir	mite
	aryla shov	-	10a. State 10b. County								1 □Yes 2	
	8a-f	Scto		imore	Cock	eysville						
	or 2	Directo	10e. Street and Number			10f. Zip Code		10	g. Citize	n of What Coun	try?	
	ath w	<u>a</u>	13801 York Roa			2103				USA		
	tems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Americ Black, White, e		
36	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Marical Exprairer must be ruffled at	by F	1 Never Married 2 Marrie	If Yes, Give	·	1 □Yes 2 🗓 No	Specify:		S	pecify: T.T.	nite	
0	hours ural'	D D	3 XWidowed 4 ☐ Divorced	Year or Dates:	16a Dasa	dant's Hevel Ossum	ation	1	Sh Kind	of Business/Inc		
5	"nat	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	(Give	dent's Usual Occupa kind of work done on DO NOT use retired	turina most of worki	ng '	bb. Killa	Of Busiliess/III	Justiy	
2	withir	重	Elementary/Secondary (0-12)	College (1-4or 5+	}		,		^	yn Home		
2	Hygid Hygid Ither	ပိ	12 17. Father's Name (First, Middle, L	04 ast)		<u>Homemaker</u>	18. Mother's Name	(First, Middle, M				
an(	ntal ed o	Be						( ,				
Ĕ	ould d Me nark	P	James Monro		100 44 33		Lulu	- L Classification	Wit		0-4-1	
ā	12 st h and 7 is n traur		19a. Informant's Name/Relationsh		I	ng Address (Street a			-		•	
altimore, Maryland 21215-0036	1 and 2 Health em 27 i		Melinda B. Cond	lon/Daughter		Hunter Fa				tion - City or To		
0	Pages nent of hant: If ite		20a. Method of Disposition 1 ☐ Burial 2 🔣 Cremation	3 ☐ Removal from State	cemetery, crei	osition (Name of matory or other plac	i			•	·	
Ē	. Рас trnen tant: jury		4 ☐ Donation 5 ☐ Other (Sp	ecity)	Atlantic	Crematory	y 8/15				, Maryla	and
Bai	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service &	( Later	2	2. Name and Addres Lemmon Fu 10 W. Pad	ss of Facility	ne of Dul	lane	y Valle	y Inc.	
					he death. Do not en:	ter the mode of dvin	Onta Road	or respiratory arre	st.	ND ZI		
			23a. Part 1. Enter the risease, or o shoot, or heart silure. List o Immediat - Cause (Final	only one cause on each line		•					Approximate Interval Between Onset and Deat	n th
1	Physician /Medical		disease or condition resulting in	-a. acc	rafie	n je	neus	nou	1			
-	Examiner		,	Due (or as a	consequence of):	1						
		_	Sequentially list conditions, if any, leading to immediate	b. — Due to (or on o	consequence of):							
	ted nsit	in	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or.							
	and and I-trar	Examiner	that initiated events resulting in death) Last	c	consequence of):							
9	be e ician buria											
68760	death certificate be executed e attending physician and of for use as the burial-transit	Medical		d								
ox 6	ding page as	-	IF FEMALE:	23c. If yes, outcome of	f nreanancy					d Data of dalling		
Bo	eath cer attendin for use	Physician.	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy	у		23	<ul> <li>d. Date of delive</li> <li>Month</li> </ul>	ery Day Year	r
o.	at the de by the a tached i	/sic	1 ☐ Yes 2 ♠No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 L	Other (specify)						
σ.	The law requires that the ate has been signed by the bage 2 should be detache	P	Part II. Other significant condition	ns contributing to death but	not resulting in the u	nderlying cause give	en in Part I	23e. Did tob	acco use	contribute to the	he cause of death	h?
Š	ires tha signed d be det	þ	A SUBMIO	0 018				1 □ Ye	20.00		pably 4 🗆 Unkn	
5	w requir s been s should I	ted	St. In .						1			
ec	law nasb	agr.	16 Cypier	wen				24a. Was an autopsy	,	24b. Were auto prior to co	ppsy findings avail impletion of cause	lable e of
<u> </u>	The	Completed by	00					perform 1 □ Yes 2	Z No	death? 1 ☐ Yes		
Vital Records,	I or Attending Physician: The law after death. Director: After this certificate has b in by the funeral director, page 2 s	Be (	25. Was case referred to medical examiner?				26. Place of Death		)			
<u> </u>	Physic this or al dire		1 Yes 2 No	Hospital: 1 ☐ Inpatier	t 2 ER/Outpatie	nt 3 □ DOA Oth	er: Nursing Ho	me 5 Resider	nce 6[	Other (Specif	fy)	
0	ding Ph h. After th funeral	Ë	27. Manner leath 1 latural 5 □ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Time o	of 28c. Injur	y at </td <td>28d. Describe how</td> <td>w injury o</td> <td>occurred</td> <th></th> <td></td>	28d. Describe how	w injury o	occurred		
0	ttendii death. tor: A the fu	atic	2 ☐ Accident investig	ation		M 1□	Yes 2 □No					
Division of	er de recto	ŧΨ	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ry - At home, farm, str (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and i State)	Number or Rura	al Route Number,	
Ō	pital or ours afte eral Dir filled in	Certification: To		<u> </u>								
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in 1			Physician: To the best of examiner: On the basis of								
	the Hos in 24 hα the Fun πpletely	edical	one)	and manner stat		Jongwieri, III IIIy U						
	To the within 2 To the comple	Σ	29b. Signature and little of certifier		15	29c. Licens	e number	29	d. Date	signed (Month,	Day, Year)	
			Mun	your I		10	1060	//	4//	4/4		
			30. Name and address of person v					/				
			F. Sanzaro M.		ork Road,	Cockeysvi	lle, Mary	vland 2	1030			
	Sta	te	31. Date filed (Month, Day, Year)	32. Fegistra								
	Registr	ar	AUG 18	2009 Laner	J. A.	andel						

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination invative notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, E. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

	1 - State Registrar	Certificate of Death Reg. No. 2009 2029								40				
in al	1. Decedent's Name (First, Middle IDA BOOK	Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 8:45 P M												
er	4a. Facility Name (If not institution SUBURBAN HOSPI)	4b. City, Town, or Location of Death BETHESDA					4c. County of Death MONTGOMERY							
	217-16-5015 1 M 2 X F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi	7192	2	9. Birth Con	nplace (State or Funtry)  MD	oreign	
	Usual Residence of Decedent  10a. State 10b. County	/	10c. City.	Town or Lo	cation							10d. Inside City I	_imits	
ector	MD BALT	TIMORE RANDALLSTOWN									1 □ Yes 2	No		
ral Dir	8910 ALLENSW00	10f. Zip Code 21133						10g. Citizen of What Country?  USA						
To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 No Specify:						Specify: WHITE			
ompleted	15. Deceder (Specify only higher Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HOMEMAKER						16b. Kind of Business/Industry  OWN HOME						
Č	17. Father's Name (First, Middle,		18. Mother's Name (First, Middle											
10 B	ISAAC BE	ERLIN				MOLL	.IE		FF	ANK_				
	19a. Informant's Name/Relations MARTIN BOOK/SON		I		ng Address <i>(Street a</i>							ip Code)		
	20a. Method of Disposition 1								DRE.	MD				
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility SOL LEVINSON & BROS., INC.  8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208													
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  PNEUMONIA  a.										Approximate Interval Between Onset and Death			
		nce of): PHOCY	DCYTIC LEUKEMIA					5 YEARS						
xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
/Medical Examiner	Due to (or as a consequence of):  d													
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	□ Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year							
d by PI	Part II. Other significant conditi	,					tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Vunknown							
Completed by Physician		24a. Was a autops perfor 1												
Be	25. Was case referred to medica examiner?		_				of Death	(Check only	one)					
	1 Yes 2 No	Hospital: 1 Ing		R/Outpatier	nt 3 DOA Othe	4 LI Nu		ne 5 Res				cify)		
cation	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	Work?  M 1 □ Yes 2 □ No												
Certifi	4 ☐ Homicide determ		City or To					(Street and Number or Rural Route Number, own, State)						
Medical Certification; To	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of perfilier  DD 43443									29d. Date signed (Month, Day, Year) 8/14/2009					
	30. Name appendires of person who completed cause of death (Item 23a) (Type, Print)  JOHN M. CHANDLER, SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814													
ie ar	31. Date filed (Month, Day, Year)		gistrar's Signatur								,		r	

		Fan	State of	f Maryland	l / Depa	rtment of H	ealth and	l Mental Hy	giene	00	00017
	1	For State Registrar			Cer	tificate of L	Death ————		Reg. No.	1117	3. Time of Death
		1. Decedent's Name (First, Middle, La						2. Date of De Month	Day	Year	7:13 P M
Physicia /Medica		Frederick Will	iam Bro	ck1ander	, III		L of Do	August		ty of Death	
Examine		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, Town, or	Location of De	ain			unde1
	н	7903 Severn Hill	Way		- A do i sebb alos sel	Sever	n If Under 24 H	rs. 8. Date of Bi		9. Birth	nplace (State or Foreign
Funeral		5. Social Security Number 6.	Sex 1X□M 2□F	7. Age (In yrs. la	Yrs.	Months Days	Hours Mi	in (Month, D	ay, Year) 5, 1940	Mai	cyland
Director		216-34-8009		69				1101011			
pur w		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 XYes 2 □ No
lanyle F sho	5	Maryland Anne An	runde1		0d	enton					
28a-1	rect	Maryland   Anne Al	under			10f. Zip Code			10g. Citizen o		
with with	Ö	317 Eagle Landi	ng Court	Condo 1	X	211					States
ms 2;	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	o- 14. F	lace - Ame lack, White	rican Indian, e, etc.
fied within 72 hours after death with the Maryland Hygiene. <b>yther than "natural", or Items 23a or 28a-f show</b> ent, the Medical Evernine must be multified at		1 Never Married 2 Married		2 <b>X</b> No		1 □Yes 2√□No	Specify:		Spe	cify:	White
ral", c	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:	10. D.	dentile Havel Occur	ation		16b. Kind of	_	
72 ho	etec	15. Decedent's (Specify only highest of	Education grade completed)	)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of t	working	1		
ithin Jan	np.	Elementary/Secondary (0-12)	College (	(1-4or 5+)		mpire	<b>~</b> /		Profes	ssion	al Baseball
ed w lygier her th		17. Father's Name (First, Middle, La	et)				18. Mother's	Name (First, Middi	le, Maiden Surr	name)	
be fill	Be		illiam	Brock1	ander,	Sr.	Fra	nces Ro	ose S	auer	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event or must be rutified at once.	မ	19a. Informant's Name/Relationship			19b. Mail	ing Address (Street	and Number o	r Rural Route Nun	ber, City or To	wn, State,	Zip Code)
12st than 7 isr traur		Dorrit Brocklan		2	317 E	Eagle Lan	ding Co	urt Condo	o K Ode	nton,	MD 21113
1 and Health em 27		20a Method of Disposition		20b. F		osition (Name of matory or other pla		Date	20c. Location	on - City or	Town, State
Pages nent of I ant: If ite		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal fron	n State	t Ariit	ndel Crem	atory 8	/18/2009	Odent	on, M	[aryland
it. Prattme		21. Signature of Funeral Service Li		WCS		22. Name and Addr Oonaldson			Cremat	orv.	P.A.
permit. Departr Imports any Inji		Maria to ()	20 Bm	195	1 1	IAII Anna	polis K	load Ude	nton,_n	aryla	mu ziii
	-	23a. Part1. El ter the disease, or conshock, heart failure. List o	omplications that	caused the dea	th. Do not er	nter the mode of dy	ing, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
		shock, heart failure. List of Immediate Cause (Final									5 months
Physician /Medical		disease or condition resulting in death)		troke o (or as a consec	nuence of):						
Examiner				ementia	,					1 year	
	ē	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a conse	quence of):						
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G								
exection and ial-tra	Exa	resulting in death) Last	Due t	to (or as a conse	quence of):						
tificate be ex g physician as the burial	ica		d								
tifical ig phy as th	ledi			outcome of pregr					-	L Data of a	Jeliueru
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	1F FEMALE: 23b. Was decedent pregnant	☐ Ectopic pregnancy			23d. Date of delivery Month Day					
death death	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		egnant at time of nknown	death 5	☐ Other (specify)			-		
requires that the seen signed by the hould be detached	hys	9 Unknown			oulting in the	underlying cause (	niven in Part I.	23e. D	id tobacco use	contribute	to the cause of death?
gned gned	N V									No 3□	Probably 4 🗌 Unknown
aquire een si ould t								24a. V	Vac an	24h Were	autopsy findings available
TECOIDS, The law requires to the has been signed age 2 should be on	ple							a	utopsy erformed?	prior 1 death	to completion of cause of ?
The law ate has be bage 2 sl	Completed							1 □ Ye	s 2X No	1 □ Y	es 2XINo
OT VITAL NET PROPERTY OF THE PROPERTY PROPERTY PAGE 28	Be							of Death (Check or		¥ 0.15 - 1.00	Daughter's
nysic nis ce direc				☐ Inpatient 2		tient 3 DOA					pecify) Residence
on of	Ë	1   Yes   2   No									
endil eath. or: A	ite	2 Accident investig		of Injury At	home farm			28f. Location	on (Street and	Number or	Rural Route Number,
JIVISION OT VITAI I or Attending Physician: T after death. Director: After this certificat d in by the funeral director, ps	Tifi.	4 Homicide determ	ined 28e. Pi	uilding, etc. (Spe	cify)	street, factory, office		City of	Town, State)		
Uital c			a Physiolan: To	the best of my k	nowledge. d	eath occurred at th	e time, date and	d place, and due to	the cause(s)	and manne	r as stated.
Hospita 24 hours Funeral etely filled	0	29a. Certifier 1 XCertifylr (Check only 2 Medical one)	Examiner: On the	ne basis of exam nanger stated.	ination and/o	r investigation, in n	ny opinion, deat	th occurred at the t			
25. Was case referred to medical examiner?   2   ER/Outpatien   28a. Date of Injury (Month, Day, Year)   28b. Time of Injury (Month, Day, Year)   28b. Time of Injury (Month, Day, Year)   28c. Place of Injury - At home, farm, street of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the public of the						29c. License number 29d. Date signed (I				signed (M	onth, Day, Year)
F3F8 DING SMG						מת	D20094 August 14, 2009				14, 2009
^ \		30. Name and address of person	who completed to	cause of death (I	tem 23a) (Tv	ne Print)					
1/0		Elliott Gorbat	v. M.D.	1411 Ma	adison	Park Dri	ve, Gle	en Burnie	, Maryl	and	21061
	- 1	ETTTOLL GOLDA	-y 11 B	2. Registrar's Sig							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 2009 7:30am M 12 Auq. Byers Jr Arthur /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Apt. 121 Baltimore 33rd St. 1050 E. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1⊠ M 2□ F 220-01-5112 90 3,1919 MĎ Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show r than "natural", or items 23a or 28a-f shov the Modeal Examiner must be notified at Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21218 Apt.121 33rd St. 1050 Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Maryes 2 No If Yes, Give Year or DatesWWII Narried 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private home Maintenance 8th Health and Mental Hygie em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Stella Proctor Arthur W. Bvers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and.
Department of Health
Important: If Item 27,
any injury or other tra Radecke Ave. Apt D Balto Md 21206 Darnell Cloude Jr/Nephew 5931 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GarrisonForestVetCemAug21,2009OwingsMills,MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL 1412 E. PRESTON ST. BALTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of John Scause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 687 Box IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Dav in the past 12 months? 5 ☐ Other (specify) 1□Yes 2□No the o 9 Unknown 9 Unknown á signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Ď METASTASES 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 □ No 1 ☐Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner; stated. 29a. Certifier Medical (Check only one)

within 24 hours a

To the Funeral C the Hospital

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who comp

Month, Day,

Year)

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** CLAYBORNE CLAUDIA AUG 2009 15 0145 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE UNIVERSITY OF MANYUAND MEDICAL CENTER If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2**X**F Hours 238-24-5173 S. CAROLINA AUGUST 25,1922 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, it we the lead other traumatic event, it we then the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the 1 X Yes 2 □ No Director BACTIMORE MARYLAND 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 13.5.A BERNICE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: If Yes, Give Year or Dates: Specify: BLACK \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BALTO. CITY PUBLIC SCHOOLS YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic ev HENRY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANDINE CLAYBORNE COAUGHIEN 28 N. BERNICE AVE., BALTIMORE, MD &1229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FORST CEMETON OR/24/2009 CAINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
SOSCPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee which N. Williams 12140 N. FULTON AVE, BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 CHEMIC BOWER Sequentially list conditions, if any, leading to immediate cause. Enter dimerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed CANCER COLON attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) signed by the a O. 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Division To the Hospital or Attending 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435619653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH MICHAEL GREEN 22 Baltimore MD 2120 GHEENE ST 31. Date filed (Month, Day, Registrar's Signature, State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 02 AM railes nwai 2009 trancis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Parkville renesis CRomure/1 ente If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 212 20 4861 123cM 2□ F Yrs. 83 4,1925 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No must be notified Director Maryland | Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ö 21221 324 Nicholson Road 'natural", or items 23a Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. or other traumatic event, the Medical Examiner 1 XYes 2 No if Yes, Give Year or Dates: 1944–46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White ρ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Steel Worker Steel Mill 10 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conway Nellie Emerick Carroll Francis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 324 Nicholson Road Essex Maryland 21221 Esther Anna Conway 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Aug 19,2009 Baltimore, Maryland 5 Other (Specify) Parkwood Cemetery 4 Donation 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disc shock, or heart faily Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: P 1 ☐ Yes 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Matural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral E 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier 30. Name and add th (item 23) 31. Date filed Month, Day, 32 Registrar's Signate State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan intersections. Completed by Funeral Be

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit P.O. Box 68760, Division of Vital Records,

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST Year 11:29 AM 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HOSPITAL CENTER Baltimore City If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Hong Kong 8. Date of Birth (Month, Day, Nov. 3, Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 092-46-6237 1938 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 KNo Director Maryland Baltimore County Baltimore Highlands 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 South Twin Circle 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: Chinese 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chang Bing Hu Quan Fong Ju 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yin Yue Deng Cheung / Wife 122 South Twin Cir., Baltimore, Maryland 21227 August 18 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2009 4 ☐ Donation \_5 ☐ Other (Specify) Catonsville, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, MD 21061 21. Signature of Funeral Service License 0 23a. Part 1. Sher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 8EPTIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner DUODENAL Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No 1 □Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗙 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and menner stated. 29b. Signatur 29d. Date signed (Month, Day, Year) M-D. RES ODI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

BALTIMORE

STREET.

32. Registrar's Signature

& HANOVER

18 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician ove August 00 per 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Medica Leuter Burnie Baltimore Washington Glen rundel three 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 26,1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 2 M 2 □ F **Funeral** Months Days Hours Min. 87 Feb. 156-07-5868 NJ Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla D\_partment of Health and Mental Hyglene. Ir portant; If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Externing In rotation and other. 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 Crain Hwy Apt. 419 21061 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Cooper Anna Gritton ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7975 Crain Hwy Apt. 419 GLen Burnie, MD 21061 Mrs June Cooper/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 2009 Crownsville, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd AVe. SW Glen Burnie, MD 21061 1100918 walle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or conditic resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 3 Probably 4 ☐ Unknown roidism 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 XN0 1 ☐ Yes 2 ☐ No a 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation neral Director: A 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hos

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:00 P Philomena Ann Colantino 14 2009 Aug. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lorien Mays Chapel **Timonium** 8. Date of Birth (Month, Day, Year)
Aug. 27 1915 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min MA 1 M 2 F 93 Director 023-09-0441 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 X No Woodstock item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21163 2107 Turnberry Way Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 XNo 3altimore, Maryland 21215-0036 Specify. þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; th and Mental Hygiene. **7 is marked other than "r** Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Caroline DiSessa Thomas DiVito ပ 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is: 2107 Turnberry Way, Woodstock, MD 21163 John Colantino/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Burnie, MD Atlantic Crematory 8/18/09 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature J. Far ral Se ice Lice Michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 I Inknown certificate has been signed by rector, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? perform 2 No 2 1 T Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 A atural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: .

completely filled in by the f the

State Registrar

29c. License number

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Omle

and manner stated.

RO80210

405, Balhmore, Md 21204

31. Date filed (Month, Day, Year)

29b. Signature and title of pertifier

29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** P. M Gloria L. Conaway 2009 /Medical 4c. County of Death N/A Fa¢ility Name (If not institution, give street and number) 4b. Gity, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, 3/3/34 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Months Hours Min 213-32-4147 75 Director MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examilmet must be notified at N/A Baltimore MD 1¥ Yes 2 ☐ No Director death with the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 820 S. Caton Ave-Apt.3K USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after Black, White, etc. **African** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <sup>Specify:</sup>American þ 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) iene. Elementary/Secondary (0-12) College (1-4or 5+) Private permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic power. Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clemus L. Smith, Sr. Mary A. Williiams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah R. Smith/Daughter 5618 Wesley Ave,Balt.,MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison ForestVA 8/24/09 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Clo 5126 Belair Rd, Balt., MD 21. Signature Funeral Service Lic. Close F.Svs,PA MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vascular a Coverney Arterioselevotre disease or condition resulting in death) In known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 righetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 s autopsy certificate performed 1 □Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပု 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 □Yes 2 □ No nours after death.

neral Director: / ∠ □ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Division of Vital Records, P.O. Box 68760, Hospital or Attending within 24 hours a To the Funeral C

DHMH 17 Rev 1/2001

completely

(Check only one)

29b. Signature and title of certifler

Bergeson 31. Date filed (Month, Day, Year)

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

gistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Arenve Baltimere Noryland

		State of Maryland / Dep		Mental Hygien	e
		State Registrar Ce	rtificate of Death	Reg. N	
Physici	ion.	Decedent's Name (First, Middle, Last)			ay Year 3. Time of Death
Physici Medie		GLORIA CAMPI	4b. City, Town, or Location of Death	1	County of Death
Examir	ner	4a. Facility Name (If not institution, give street and number)	Baltimore City	•	s. County of Beauti
		The Johns Hopkins Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Funeral Director		214 50 2722 1 M 2 X F 62 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 10	9. Birthplace (State or Foreign Country) MD
Т		Usual Residence of Decedent			10d. Inside City Limits
arylar s <b>ho</b> v	2	10a. State 10b. County 10c. City, Town or L	altimore		Yes 2 No
he Ma 28a-f otifie	Director	MD n/a B	10f. Zip-Code	10a C	itizen of What Country?
iore, Maryland ZIZIS-UU30 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ä	815 Glover St.	21205		USA
death ms 2: must	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
after or ite		Armed Forces?  Never Married 2   Married   1   Yes 2   No   If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	nican, etc.)	Black, White, etc.  Specify: black
5-UU36 72 hours aft natural", or	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		16h	Kind of Business/Industry
"natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation  e kind of work done during most of wor  DO NOT use retired)		Tally of Business/industry
within ene.	d mo	I Flementary/Secondary (0-12)   College (1-4 or 5+)   I	chine operator		Battery Co.
Hyge other	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	en Surname)
//ar/	10 E	Robert Campbell		Marshall	
Mar) d 2 sho th and l 7 is ma trauma			ing Address (Street and Number or Ru		
and and fealth m 27			7 Marshes Gleni		SS, GA. 30071 Location - City or Town, State
IOre		t Rurial 2 Cremation 3 Removal from State Cemetery, cr	y Cemetery Au		•
Saltimor  bermit. Pages Department of mportant: If it any injury or o			y Cemetery Aug 1 Name and Address of Facility gg:		
baltimore, I permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		Dognadano // Vone	412 E. Preston	St. Balt	o,Md. 21213
	1	23d. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition a. SEPSIS			Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of):			
Examiner	<b>1</b>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ed sit	Examiner	if any, leading to immediate cause E ter underly Cause (Disease or injury			
be executed ician and burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):			
sate be executed by social and street and street burial-transit street burial-transit	dical	d			
certificate ding physical use as the	Ψ.	IF FEMALE:			ļ
COrds, P.O. BOX 68 v requires that the death certific been signed by the attending plantund be detached for use as	Physician/M	23b. Was decedent pregnant  in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery  Month Day Year
e death he atten	ysic	1 ☐ Yes 2 No	Other (specify)		
hat the detach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ecords, P.O. law requires that the is been signed by the 2 should be detach.	d by			1 🗆 Yes	2 No 3 Probably 4 🕱 Unknown
v requ	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The law ate has b page 2 s	E E			performed?	death?
VITAI HE sician: The la certificate has irector, page 2	Be C	25. Was case referred to medical examiner?		ath (Check only one)	
OT VITA Physician: this certifica ral director,	1º	1 ☐ Yes 2 🛣 No Hospital: 1 🔀 Inpatient 2 ☐ ER/Outpati		lome 5 Residence	
On Or ding Phys h. After this of funeral di		27. Manner of Death 1 ★Natural 5 □ Pending (Month, Day Year) 28b. Time (Month, Day Year)	/ Work?	28d. Describe how in	jury occurred
i i i i i i	cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s	M 1 Yes 2 No	28f. Location (Street	and Number or Rural Route Number,
or Al after a Direc	Certification:	4 ☐ Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta	
To the Hospital or Attending within 24 hours after cleath. To the Funeral Director: After completely filled in by the fune		29a. Certifier (check only (check only 1 Medical Examiner: On the basis of examination and/or			
he He he Fu	ledical	one) and manner stated.			
To To To Com	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		C duyman, MEDICAL DOCTO		FICE	.031
		30. Name and address of person who completed cause of death (Item 23a) (Type CHRISTINA TWYMAW		North Wolfe	St, Baltimore, MD, 21287
St	ate	31. Date filed (Month, Day, Year) 32. Begistrar's Signature		·	
Regist		AUC 18 2000 A	a. N.S.		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** James Richard Carr, Sr. /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) nedical Examiner Washington Burnie (3/len Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year) Min. Months Days Hours 1**√√**M 2□ F 212-24-7508 Director Sept 28, 1929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Moder Exprise must be notified at any injury or other traumatic event, it is Moder Exprise must be notified at any once. 1 ☐ Yes 2 ₩No Director Brooklyn Park Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5112 Wasena Ave 21225 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🕅 No If Yes, Give Year or Dates: Specify: Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Escort Nissan Auto 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charmaine Galante Daughter 5112 Wasena Ave, Brooklyn Park, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veterans Cem Aug 18, 2009 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fink Funeral Home, P.A. nor of Funeral Service Gregoxy Fir 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part Enter the dispase, or heart ailu e. L Immediate C use (Findisease or control on resulting in death) 0 Physician /Medical Due to (or as a consequence off Examiner Sequentially list conditions, Due to for as a conse wence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burlal-transi Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 12 No 1 TYes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) 27. M nr of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

E

29b. Signature and title of certifier

Jeovae

(Check only one)

32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mame and address of person who completed cause of death (Item 23a) (Type Print) Josephal Drive, Glen Burnie, MD 2016)

D41365

29d. Date signed (Month, Day, Year)
Angust 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) DICKENS Year **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Home OPINCE ROSA NURSING 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, | Months | Min. | Months | Months | Months | Min. | Months | Months | Months | Min. | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Mo Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖬 F 57703 8482 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 Yes 2 □ No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Modical Experiment must be mutilled Funeral Director AUNIE GEORGES MITCHELLVILLE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20121 3900 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ပ SEYMOUIC 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DAVINTER 2433 NAPA VALL Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part . Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** A disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a Was an 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: An the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending within 24 hours after death. To the Funeral Director; After

> State Registrar

29b. Signature ar

(nAm

31. Date filed (Month, Day, Year)

d title of certifie

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAN

32. Registrar's Signature

DHMH 17 Rev 1/2001

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9500

**ORIGINAL** 

29c. License number

32261

ALLAROWS No. LAMON MA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8/15/2009 Day **Physician** Kenneth Joseph Dean 11:50 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (Il not institution, give street and number) **Examiner** Carroll 1002 Merridale Blvd. Mt. Airy If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
DC Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 7/31/1939 Months Days XXM 2□ F 70 Director 213-40-5242 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21771 1002 Merridale Blvd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. White 1965 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Joyce Phillips John Joseph Dean 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Dean/Wife 1002 Merridale Blvd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/18/2009 Winfield, MD Carroll Crematory 21. Signature Funeral Service Lice Fe Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. Part / Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capies on each line. Immediate Jause (Final disease or condition resulting in death) ancreat **Physician** Comcer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1☑Yes 2☐ No 3☐ Probably 4☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Natural 1 □Yes 2 □No investigation 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

X

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Mooth, Day Year)

18

Dono

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vonejkovi7 32. Registrar's Signature

1🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Physician /Medical **Examiner** 

**Funeral Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Exercite many.

Baltimore, Maryland 21215-0036

**Physician** /Medicai **Examiner** 

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. I Division of Vital Records, hours after death.

Ineral Director: After this
y filled in by the funeral di

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Month 12:30a M Vincent Alan Dawson Aug 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 508 S. Port Street N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8 - 27 - 1945 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 1**™** M 2□ F 214-44-9426 63 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 508 S. Port Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status □Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Longshoreman Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Dawson Thelma Hudson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia Reiber - Daughter 7802 Eastdale Road Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory: 8-19-09 | Baltimore, MD 21. Signature of Fundel Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic 6 mon resulting in death) Due to (or as a consequence of): Sequentially list conditions, Dige to for as a consciousive off Examine If any, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2XINo 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 💹 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Raven Blvd, Baltimore, MD 2039 Ragett, MD, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

within 24 ho

To the Function

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TEM# /,#20b,perfH,#30perDVR,8894,8/18/09,WS

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 7:15 AM **Physician** 08 2009 Janue arah /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Cheverly Prince George's Prince George's County Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 5, 1940 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 241-76-9563 1 ☐ M 2 🔀 F NC Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be rediffed at once. NC Edgecombe Rocky Mount 1XYes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 27801 USA 1600 Chase Street Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian County / City School Sys. 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Norwood Lee Sallie Cooper ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7713 Merrick Lane, Hyattsville, MD 20785 19a. Informant's Name/Relationship (Type. Print) Byron Daniels Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 ☐ Cremation 3 ₺ Removal from State Old Mark Chapel Church 8/22/09 Rocky Mount, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall <sup>22</sup> Charles L. Stevens Funeral Home Inc. - Marshall 1501 East Fort Avenue; Baltimore, MD 21230 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** ardiac MIN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronau if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-trans physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. ğ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? After this certificate 1 ☐Yes 2 ☐ No monary ul To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Ridge Clinic 7582 Annapolis Road Lanham, Md. 20784 D. Green 31. Date filed (Month, Day, Year) AUG 18 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PI line b, & 25, per ME g894 8724/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Dav Month Physician PM 3:27 3 2009 ictoria /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Center of Maryland Medical University If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 1, 1 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country)
Maryland Min. Days 1 M 2000 Months Hours 213-94-9390 45 1964 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show ral", or items 23a or 28a-f show 1 Xes 2 □ No Director Maryland | Prince George's Laurel 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 14038 Chestnut Court 20707 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★\*No 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married XX Married If Yes, Give Year or Dates: 1 □ Yes 2 🗓 🖔 Specify: Specify: 2 White 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Training Coordinator Justice Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Rhoads Martha Bartko ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 14038 Chestnut Court Laurel, Maryland 20707 Harry T. DuBois, III/ spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XX emation 3 ☐ Removal from State W. Arundel Crematory 08/17/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se vic licensee <sup>22. Name and Address of Facility</sup> Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 -M00770 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock or heart failure. Li. Immediate Cause (Final Brain Hermation **Physician** disease or condition resulting in death) / /Medical Due to (or as a consequence of) represent Examiner intra cerebra EWOTE Sequentially list our fittings if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner HOVED BY MEDICAL EXAMINER burial-trar CERTIFICATION NO Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Vear ō Day 5 ☐ Other (specify) ed by the 1 ☐ Yes 2 X No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown ltyperteusion should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 □Yes 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 🗆 Accident reral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funeral Direc 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

within 72 hours after death with the Maryland

filed within I Hygiene.

and 2 should be

The law requires that the death certificate be executed

Physician:

the Hospital or Attending

death.

Box 68760,

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of Vital Records,

Division

Baltimore, Maryland 21215-0036

Crandall M.D Kenneth

225. Greene St. Baltimore, MD

2009

31. Date filed (Month, Day, Year) 32. Registrar's Signature 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jake

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 THELMA MELLEIME DONALDSON August 4:30 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel regional Hospital Prince George's Laurel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗌 M Maryland 578-10-4298 98 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mines are once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2☐No Director MD Anne Arundel Severn 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1706 Crossbay Court 21144 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forceş? 11. Marital Status Black, White, etc. 1 Yes 22 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X X 1 ☐ Yes 2 🗓 No Specify. Specify: þ XXWidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Melleive Donaldson Edward Lee Harman ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth K. Harman/sister in law 1706 Crossbay Court Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XX Burial 2 □ Cremation 3 □ Removal from State Trinity Church Cem. 8/17/2009 Woodwardville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. Li r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t only one cause on each line. Immediate Cause (Final Physician Septic Shock disease or condition resulting in death) · /Medical Due to (or as a consequence of) Examiner Urinary Tract Infection Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ X № Month Year 4☐Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ ✗o 24a. Was an certificate has autopsy performed? 2 XIX or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes XX No 1 XX patient Certification: To 2 □ EB/Outpatient 3 □ DOA After this 27. Manner of Death 1 Antural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Hospital 29a. Certifier 1 XIX-ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60936 August 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul Tak, M.D. Laurel Regional Hospital 7300 Van Dusen Rd. Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ith Day	Yea	ır	of Death
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	Union Memorial  5. Social Security Number	HOSPITAL 6. Sex	7. Age (In yrs. la	oct hirthday)	If Under 1 Year	If Under		8 Date of Birt	N/		Birthplace (Sta	te or Foreid
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5	11. Marital Status 1 ☐ Never Married 2 ★ Married	Armed Fo	orces?	. 13.	If Yes, specify Cuba	in, Mexicar	n, Puerto	Rican, etc.)		Black, Wi	hite, etc.	1
2	3 ☐ Widowed 4 ☐ Divorced	If Ves Gi	ve Dates: WWII		1 □Yes 2 <b>X</b> No	Specify:			Spe	ecify:	White	
200	15. Deceder	nt's Education est grade completed)	T		dent's Usual Occup		t of work	rina	16b. Kind o	f Busine:	ss/Industry	
Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life. I	n Design	1)			Abordo	on D	roving	Crou
	12 17. Father's Name (First, Middle,	5+		weapo	ni besign			e (First, Middle,			TOVING	GLOU
2	Charles Edgar I							a Eliza			<b>,</b>	
2	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street							
	Emily P. Evans	Wife										
	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery crematory or other place)  20c. Location - City									or Town, State	)	
	15 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Dula	aney V	alley Men	noria	1 8/	22/2009	Cocke	ysvi	.lle, M	D
	21. Signature of Flueral Service Licersee											11
	num	(P) . XX	2n11)	/   5	Grades-inci	アンシーハ	CT (-4	r micra				1 1
		Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland Stands, or heart failure. List only one cause on each line.										
	23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that tonly one cause on	caused the death		ter the mode of dyir	ng, such as	cardiac	or respiratory a	rest,	ylan	Approxi Interval	mate Between
	shock, or heart failure. List Immediate Cause (Final disease or condition	r complications that tonly one cause on	caused the death		ter the mode of dyir	ng, such as	cardiac		rest,	ylan	Approxi Interval	mate
	shock, or heart failure. List Immediate Cause (Final	aa	caused the death each line.	Do not ent	ter the mode of dyir	ng, such as	cardiac	or respiratory a	rest,	ýlan ,	Approxi Interval	mate Between nd Death
5	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Due to	(or as a consequ	Do not en	ter the mode of dyir	ng, such as	cardiac	or respiratory a	rest,	ýlan ,	Approxi Interval	mate Between nd Death
<b>P</b>	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Due to	each line.	Do not en	ter the mode of dyir	ng, such as	cardiac	or respiratory a	rest,	ýlan	Approxi Interval	mate Between nd Death
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State Registrar factor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) EVANS, SRAUGUST Year **Physician** 15 15 M LEE 2000 MAURICE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORF NAJOHNS HOPKINS BAYVIEW MEDICHL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Funeral 1 X M 2 □ F Months Days Hours Director 220-20-5854 Feb. 10, 1929 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at XX Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 4419 Newport Avenue permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give Korea 1 ☐Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 12 Transit Authority 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Elmer Evans Elizabeth Day 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alice Evans Wife 4419 Newport Avenue, Baltimore, Maryland 21211 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 8/19/2009 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Page And Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland m Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dyneart failure. List only one cause on each line. Immediate Cause (Final ADRITIC STENOSIS YEARS Physician CRITICIAL resulting in death) /Medical Due to (or as a consequence of): HEART DISEASE 25 TEARS Examiner RIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 **N**o 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending ours after death.

neral Director: A
filled in by the fr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

JENNIFER CHEN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (item 23a) (Type, Print)

EASTERN AVENUBALTIMORE MD 21224

29c. License number

RES-001

29d. Date signed (Month, Day, Year)

AUGUST 16, 2009

loseph Edem	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No. 2009 2626
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month Day Year
(	4a. Facility Name (if not institution, give street and number)  Washington Adventist Hospital  4b. City, Town, or Location of Death  Takoma Park  4c. County of Death  Montgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign NIGERIA Country)
Maryland 28a-f show any d at once. rector	Usual Residence of Decedent  10a. State
the Maryland Sa or 28a-f sh otified at once	10e. Street and Number 7206 16th PLACE 10f. Zip Code 20786 10g. Citizen of What Country? NIGERIA Canada
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	or Dates:  Or Dates:  Also Department Liquid Countries (Specification of Specification City)  Also Department Liquid Countries (Specification of Specification of Specification City)
21215-0036 buld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	EDET EDEM EDIM ESSIEN
MD 21 nd 2 should alth and Mes em 27 is man aumatic ev	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1 rene Zama/friend  8491 Greenbelt Road #201, Greenbelt, MD 20770  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Departion 5 Other Specify: George Washington Cem Aug 29 2009 Adelphi, MD
Balt Bermit. Departit Import	21. Signature of Fineral Service Licensee  22. Name and Address of Facility  J. B. Jenkins Funeral Home  7474 Landover Road, Landover, MD 20785  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Asphyxia  Due to (or as a consequence of):
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  b. Choking  Due to (or as a consequence of):
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760, icate be execute physician and the burial - tran	UNPENDED  X AMENDED I tem#10g,perFH,G894,8/31/09,WS  IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1   Live birth   Day Year
ords, P.O. Box 6876 aw requires that the death certificate has been signed by the attending phy 2 should be detached for use as the hypeteed by Physician/M	23b. Was decent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)  g Unknown
S, P.O. uires that the n signed by Id be detached by Pleached by P	1 Yes 2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The aw requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, age 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Exhibitation: To Be Completed by Physician/Medical Exhibitation:	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?  1 V Yes 2 No 1 V Yes 2 No
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Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation   Jul 31, 2009   1630 hrs   28f. Location (Street and Number or Rural Route Number, City or Town, State)   4 Homicide   4 H
Division of Vital Rectiviting the Ilospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director. To Medical Certification: To Be Com	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
• ×	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 1, 2009
5	30. Name and address of erson who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month 0932 AM **Physician** 2009 Rosie Ely AUG 71 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore N/A AGNES HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2**X** F 1, Director Aug. 1932 215-74-4865 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD 1 ☐ Yes 為 No **Funeral Director** Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4711 Washington Blvd. 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Ilmportant: If Item 27 is marked other than any injury or other traumant. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mike Ristic ဥ Bessie Ziko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Elv - Husband 4711 Washington Blvd., Baltimore, MD 21227
of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Removal from State 3 ☐ Removal from State 4 ☐ Removal from State 5 ☐ Removal from State 5 Other (Specify) 8-17-2009 | Baltimore, MD Western Cemetery ure of Funeral Service Licens 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. mot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): EIV Rose Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b autopsy perform this certificate 2 **2**00 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 npatient 27. Manner of Death 1 XX Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
leral Director: /
filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2. and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 924056

State Registrar person who

Hmjad

and address of

faria
31. Date filed (Month)

900 Caton Ave, Baltimore MD 21229

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

St. Agnes Hospital.

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9

				Cen	tificate of	Death	R	eg. No.	
		1. Decedent's Name (First, Middle, Las	t)				2. Dete of Deet Month	h Dey Year	3. Time of Death
	sician edical	Joy Lynn Frankli	n				August		5:45 AM
	miner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or I	ocation of Death	4c. County of Deeth	1
		North Hampton Ma	nor			Frederi		Frederic	
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pu »		Usuel Residence of Decedent  10a. State 10b. County	100	City, Town or Loc	ation				10d. Inside City Limits
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he N	ect .	MD Frederic	K F	-	1	0g. Citizen of What Co	unto/?		
with of	늅	200 E. 16th Stre	<del>.</del>	'	U.S.A	-			
eath 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in	pecify Yes or No-	14. Race - Amer				
ter d	Ş	1 Never Married 2 Married	Armed Forces?	pecify Yes or No- o Rican, etc.)	Black, White	e, etc.			
rs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Specify:		Specify: Wh	ite		
Q Z1Z15-UUZU illed within 72 hours after death with the Manyland Hyglene. Infiner then "natural", or items 23a or 28a-f show mit the Medical Experience must be notified at mit. It we Medical Experience must be notified at	Be Completed by	15. Decedent's Edi	ucation	pation		16b. Kind of Business/l	Industry		
21215-UU2U sd within 72 hours afi gjene. or then "natural", or the Medical Exam	ple	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give k	and of work done ONOT use retire	during most of world)	rking		
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2 sho and I me		19a. Informant's Name/Relationship (7						, City or Town, State, Z	
and and and and and and and and and and		Nicole Campbell/				street, #		erick, MD	21701
S T T T T T T T T T T T T T T T T T T T	5	20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐		<ul> <li>Place of Dispos cemetery, crem</li> </ul>	sition (Name of atory or other pla			20c. Location - City or	
Peges nant of h	2	4 ☐ Donation 5 ☐ Other (Specify		rdent Cren	ation Ser	vices	08/11/2009	Hanover, N	Maryland
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importment of Health and Mantal Hygiene. Importment: If item 27 is merked on their then "natural", or items 23e or 28e-1 show any Initiv or other fraumetic event. Its Medical Experience must be notified.	DUCE.	21. Signature of Funeral Service Licens			Name and Addre	ess of Facility Ar	dent Cre	mation Serv	vices
n aaes	8	Laur C. Hay	dosta Mon	97 75	22 Conne			N, Hanover	
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Physicia	ian	STOOK, OF HOUR PAINTS. LIST OTHY	and daddo on dada mile.	1.1	0	1	1	1 4	Onset and Death
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OLVISION OF CONTROL OF Attanding Physical death.  Diractor: After this din by the funeral di	Cat	2 Accident investigation 3 Suicide 6 Could not be		t home form stre			28f. Location (S	treet and Number or Ru	ural Route Number.
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o the o the	×	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (Mont	h, Day, Year)
F ₹ F 8	,		Λ Δ	1	D.	58391		8-11-5	9
1 /		30. Name end address of person who co	completed cause of death (II	tem 23a) (Type F	Print)	,0011	A	0 1	1
I V		SATTADIA	212, MM	ROI-	Talli	tonse	Ane.	Freder	Jely MD
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature		•	1		21701
Dom	ictror	ALIC 1 Q acces	6	- 1					41 + ()

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Aug.9 2009 9:20 A Ruby LaRue Fialkewicz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 409 Dale Avenue Baltimore Overlea 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 - M 20 **Director** 82 Nov. 27, 1926 Kentucky 404-26-4253 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore MD Overlea 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö "natural", or items 23a 409 Dale Avenue 21206 USA 2 should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 23: Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 2 Specify: white 3 Widowed 4 Divorced Year or Dates: Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seven Eleven Cashier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Holland Hattie Lee Sturgell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun S Leon Anthony Fialkewicz-spouse 409 Dale Avenue-Overlea, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem.
Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Timonium, Maryland Aug. 12, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 0088 Harford Rd. Evans Funeral Chapel 15 Parkville, MD 21234 tado KYI and Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 12 10 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 **N**o 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after dea... \*al Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 866

State Registrar 31. Date filed (Month, Day,

P.O. Box 68760.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar's

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per FH g894 8/18/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day Year CHARLES FIEL DS AUGUST 15, 2009 806 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Good Samaritan Hospital Baltimore If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05 11 4 Days **№** М 2 🗆 F Yrs. 62 NC 241-78-5283 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21212 911 Marlau Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married X Married 1 ☐ Yes 2√ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Jarvis Steel Elementary/Secondary (0-12) College (1-4or 5+) 8th grade na Forklift Operator Lumber Company 8 Mother's Name (First, Middle, Maiden Surname) Fannie Colvin 17. Father's Name (First, Middle, Last) Jerry Field Fannie Mae Colvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Marlau Drive, Baltimore, Md 21212 Joyce E. Fields-Wife
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/22/09 Woodlawn, Md Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition unknow SCUT resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that is interested.) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4-DUnknown ABETES 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

d other then "natural", or items 23a or 28a-f ehow event. The Medical Examiner must be notified at

death

filed within 72 hours after I Hygiene.

Pages 1 and 2 should be fill ent of Health and Mental H. It if item 27 is marked oth y or other traumatic eventy

permit. Page Department of Important: If eny injury or once.

Baltimore, Maryland 21215-0036

physicien and s the burial-transit ths Hospitel of Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, as signed I Division of Vital

death

within 24 hours after c To the Funeral Direct

Completed by Physician/Medical ٩ Atter thi Director: /

Examiner 25. Was case referred to medical examiner?

1 1 Yes 2 No 27. Manner of Death Certification:

Medical

IF FEMALE:

autopsy performed? Yes 26 No 1 ☐ Yes

24b. Were autopsy lindings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred

28b. Time of 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Thale to )

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only

4 Homicide

29c. License number 0018230 ANGUST 15,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending

investigation

6 Could not be determined

1 Inpatient

28a. Date of Injury (Month, Day Year)

21

Outpatient

Good Samanton Hospital, MD 21239

SHASH DHARAN KALA THIC 31. Date liled (Month, Day, Year) 32. Registrar's Signature

barke 18 2009

Registrar

State

			For State Registrar	State of Maryla				lealth and Death	Mental Hy	giene Reg. No 2	09	26270	)
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١. '	Physicia Medic		William A.	Fritts					8	15 20	009	11:13 P N	1
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	uneral irector		210-20-7017	EX M 2□F 7. Age (in yrs	s. last birthday) Yrs.	Months		Hours Min		26 Year)	Cour	va VA	μı
and	W		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limit	s
Maryl	f sho	호	MD Anne Ar	unde1	Mi.116	ersvi	sville 10					1 □Yes 2 🔯 N	0
the	28a-	Director	10e. Street and Number			10f. Z	ip Code			10g. Citizen of \	What Cour	ntry?	_
with	3a ol	<u>_</u>	613 Waterwheel La	ne #11			2110	3		US	A		
<b>5-0036</b> 72 hours after death with the Maryland	n result and result of the Modical Examination of the modified at other traumatic event, the Modical Examination and prolified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Was Dec If Yes, sp 1 □ Yes		lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rac Blac Specify	ck, White,	can Indian, etc. ite	
<b>21215-0036</b> d within 72 hours aff	han "natur	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation ide completed)  College (1-4or 5+)	life.	kind of w DO NOT	ork done use retired	during most of wo	orking	16b. Kind of Bi	usiness/In	dustry	
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Maryland of 2 should be file	ed of	Be C	John W. Fritt					Nettie	,	ıvall	10)		
aryland should be f	mark	ဥ	19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	na Addre	ss (Street		Rural Route Numb	er. Citv or Town.	State, Zin	Code)	
Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma M	27 is r trau		Mrs Virginia Frit	• • • • • • • • • • • • • • • • • • • •	1				11, Mill				
star Hes	item		20a. Method of Disposition		Place of Disponentery, cre	osition (N	ame of	20)	Date	20c. Location -	City or To	own, State	
Page	nt: ⊩ ry or		12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		en Have				0/2009	Glen B	urnie	, MD	
Baltimore,	Important: If item 27 is any injury or other training.		21. Signature Filter i Sryce Live					ss of Facility K Hwy SE,	irkley-F Glen Bu	Ruddick D rnie MD	Funer 2106	al Home 1	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	dications that caused the dea	ath. Do not en	ter the m	ode of dyir	ng, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between	
Phy	sician	g n	Immediate Cause (Final disease or condition	Metasta	die	/ 1	on	Cance	4		3	Onset and Death	
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Exa	miner	L	Sequentially list conditions.	b. =									
200	siţ	jne	Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events	Dust to (or es a consequence of):							- 3		
M. Secure	physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):								
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<b>687</b>	phys s the	edic		_ d									
of Vital Records, P.O. Box 68760, C. Physician: The law requires that the death certificate be executed	by the attending patached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□ Ectopic □ Other (	pregnanc (specify)	у			ite of deliv	ery Day Year	
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ohysi	this o	ဍ	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2				4 LI Nursing	Home 5 ☐ Res			fy)	
□ E	After this certificate ha funeral director, page	Ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		28c. Inju Wor	ry at k?	28d. Describe	how injury occur	red		
Division To the Hospital or Attending	To the Funeral Director: completely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of Injury - At	home, farm, st	M reet, facto	L	Yes 2 □ No	28f. Location City or To	(Street and Numi wn, State)	ber or Run	al Route Number,	
Div Fo the Hospital or within 24 hours afte	ne Funera	Medical C	29a, Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my ki niner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurre	ed at the ti	me, date and pla opinion, death oc	ce, and due to the	e cause(s) and m , date and place,	anner as and due t	stated. to the cause(s)	
To th	To th	Me	29b. Signature and title of certifier			2	9c. Licens	se number		29d. Date signe		Day, Year)	
			1 2/1	10			D006	58976		8/15/20	009		
	4		30. Name and address of person who Girum Beyene, MD	completed cause of death (Ite 5309 Manorfi	em 23a) (Type Leld Rd	Print)	ockvi	.11e MD	20853				
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature	w. J	. •						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ĭ¼, 20\b°9 17:16 pM Ann Finstad August Tracy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Co. Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 F Hours Yrs **Director** 28, 1964 Maryland 218-94-0678 Aug. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Middoll Even, from it ust be notified at 1 □Yes Z∏No Funeral Director Maryland Glen Burnie Anne Arundel Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7854 Cindy Drive 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 No .0 1 ☐ Never Married 2 👿 Married Maryland 21215-0036 Completed by 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospita1 12 yrs. Patient Account Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental ant: If item 27 Is marked o Carol Hobgood Aubrey Charles Tabor Betsy ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy E. Finstad, Sr./Husband 7854 Cindy Drive Glen Burnie, MD Baltimore, Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Park | 08/19/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01121 Services PA; 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of bowel Physician gangrine days resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 X No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Situal Black, MD 8/14/09 146052 30. Name and address of person who completed cause of death (kem 23a) (Type, Print) (Type, Print) (An apolicy) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 1 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hyglene  1- Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Contributed of Death  Reginery  Reginery  Contributed of Death  Reginery  Reginery  Reginery  Contributed of Death  Reginery  Reginery  Reginery  Contributed of Death  Reginery			Please	e Type or Pri						_		_	ible.			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** osep /Medical or Location of Death 4c. County of Death Name (If not institution, give street and number, 4b. City, Town, **Examiner** Medica Cente more If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Feb. 4 Sex 14 M 2 F 7. Age (In yrs. last birthday 53 Yrs. 5. Social Security Number . 1<u>956</u> **Funeral** Days Months Maryland 213-72-5113 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Newlord Experiment to the beautiled at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Baltimore Director Lansdowne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3228 Tartarian Ct. 21227 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 □ Yes 2 □ No Specify: Race - American Indian, 11. Marital Status Black, White, etc. White 1974-Never Married 2☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: 1976 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Roofer Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John C. Flemister, Sr. Joan A. Wargo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Moore's Crossing Unit 20 Millsboro, I 19a. Informant's Name/Relationship (Type. Print)

Joan Flemister, mother permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 19966 Millsboro, DE. 20c. Location - City or Town, State 20b. Place of Disposition (Name of MD Veregram 'S' Cemertery 8-19-2009 of Crownsville 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Ambrose Funeral Home, Inc 1328 Sulphur Spring Rd. 21. Signature of Funeral Service Licenses Arbutus, MD. <del>21227</del> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Syes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 Z No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reene St. 10 Himore.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Physician Month 17, August 9:30 A. M Brejohi Gharakhanian /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harford Hart Heritage Hospice If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Mar. 21, Street Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Director 494-04-0742 81 1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it a Mudical Examinal must be notified at 1 ☐ Yes 2 ☑ No Director Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21015 Funeral 1704 Globe Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: Middle 3 Widowed 4 Divorced Fastern Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Unknown Unknown ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is a any injury or other trau 1704 Glove Court Bel Air, Maryland 21015 Jirair Gharakanian / Son 20b. Place of Disposition (Name of Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Commeten Comme 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donation Forest Hill, Maryland Bel Air 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Service-Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Rememtos END **Physician** Stree disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. En and common cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 200 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 Bother (Specify Hospice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 35885 no W. MACPHAIL Bel Air MD 21014

State

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ALGRAD SCANICS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:45 Goldberg 15 2009 Norma August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7506 Schooner Lane Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M Director 81 Nov 24, New York 125 20 1806 1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show purmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla D partment of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ib. Medical Evan. Incrinist by netiting 31 once. 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7506 Schooner Lane 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gus Bush Theda Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Goldberg (husband) 7506 Schooner Lane Middle River Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem Gardens 8/19/2009 Middle River, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death 23a. art1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) cespira /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events un Due to (or as a consequence of Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year P.O. I signed by the a 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?/ Yes 2 No COPID 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To eral Director: After th filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a

To the Funeral C

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

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18 2009

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

**Physician** /Medical Examiner

**Funeral** Director

Director

by Funeral

Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 'natural", or permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event Item."

filed within 72 hours after death

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

sician and burial-trans physician the burial P.O. Box 68760. attending pl Division of Vital Records, s been signer should be c certificate has page 2 or Attending Physician: director, After this of funeral din 24 hours after death. completely filled in by the

1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:25 P. M Phyllis M. Gardner August 16, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12107 Tullamore Ct. Unit 402 Baltimore Lutherville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 10/02/1945 7. Age (In yrs. last birthday) Days Hours Balt., Maryland 1□ M 2/5 F 63 215-44-0105 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Lutherville 1 ☐ Yes ŽÍNo 10g. Citizen of What Country? United States of America 10e. Street and Number 21093 12107 Tullamore Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2 ☐ Married 1 ∐Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Information 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director of McCormick Technology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean E. DeVilbiss Albert Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12105 Tullamore Ct. Unit 101 Lutherville, Maryland
21093 19a. Informant's Name/Relationship (Type. Print) Jean E. McDade/ mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel - Bel Air Date 20c. Location - City or Town, State 20a. Method of Disposition August 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature Dineral Service Licensee 22. Name and Address of Facility
eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Mmonary 6BStRUETIVE DISRAS Due to (or as a consequence of): emply sens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 ☐ Mo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yeş Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) AZ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. May er of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 150760 ed cause of death (Item 23a) (Type, Print) Lutrevalle, mo 21093 . CHARLES WENG 307 40 + STE 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

To the Hospital

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 11, 2009 Freda R. Groomes 7:50 P M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A Baltimore 1110 Woodheights Avenue Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1□ M **%**F Months Days Hours Min. 212-28-6271 88 2-15-1921 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits tx Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 1110 Woodheights Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 🛠 No Specify. white 35 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Information Operator 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Noreen Frederick Llovd Baltzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Woodheights Avenue Baltimore, MD 21211 (Daughter) Beverly Mulcahy 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State ★₩ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/15/09 Lake View Memorial Pk Sykesville, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Baltimore, Maryland 21211 3631 Falls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Elevation Myocardial Infarction Immediate Cause (Final 7days disease or condition resulting in death) Due to (or as a consequence of): enoscherosi. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 1 ☐ Yes 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident

Physician /Medical Examiner The law requires that the death certificate be executed Exami

**Physician** 

/Medical

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**Funeral** 

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Box 68760,

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within 24 hours after death

To the Funeral Director:
completely filled in by the

Director

Funeral

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burial-transi and attending physician for use as the buria ed by the signed to be detail cate has by page 2 s certificate director this

After th funeral

Physician/Medical

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Completed

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Certification: To

Medical

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 📂 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

6 Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

Northern Parkucy #101, Baltimore Jusan J Henley 1190 West 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

3 Suicide

4 Homicide



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:00 PM 2009 Levarn Graham III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hopkins Bayview Medical Center Baltimore 8. Date of Birth 8-12-2009 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Mary land 1**X** M 2□ F 30 Director N/AUsual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4400 Furley Avenue 21206 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: Biracial 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Levarn Graham II Dawn Slabaugh ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4400 Furley Avenue Baltimore, MD 21206 Dawn Slabaugh - Mother Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Ki Cremation 3 ☐ Removal from State Bayview Crematory 8-17-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Umhilical disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled in by the funeral director, page 2 autopsy Hospital or Attending Physician: The 2 No 2 No i □Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¹XYes 2 □ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a া Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated within 2 To the I

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

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Dr. Alison

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chapma

29c. License number

Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 00:07 M Boris (Tlispy 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | 1 / 24 - 19 5 37 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 **∑** M 2 □ F 214-58-6418 56 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Extralised must be profilled at 1 XYes 2 ☐ No Director MD Baltimore Baltimore City 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 **USA** 1519 McKean Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 → No Specify: Specify: Black ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical contractor electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adell Unknown Unknown Glispy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21217 1519 McKean Avenue Christine Glispy-Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8-14-2009 Glen Burnie MD Atlantic Crematory Donation 5 □ Other (Specify) Signature of Furer I Service Licens 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Seps15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year Day 5 Other (specify) ned by the a detached for 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? after death.

I Director; After din by the funers 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number most mo P22955 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore, Maryland Dina Ismail 22 South Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland / De State of Maryland / De State Amend Item 25 per dr., g894	epartment of Health and N Certificate & Death		ne N.2009	26280
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Mary Elizabeth Gillis		2. Date of Death Month August	8 <sup>ay</sup> 200 <sup>ye ar</sup>	3. Time of Death 4:00am M
	/Medic Examin		Mary Elizabeth Gillis  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
i.			6509 Carroll Highlands Road	Sykesville		Carro	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye Aug. 31,	1929 9. Birth	nplace (State or Foreign IntryMD
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town of the county	or Location			10d. Inside City Limits
	a-f she	ctor	MD Carroll	Sykesville			1 ☐ Yes 2/☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	sath w	Funeral	6509 Carroll Highlands Road  11 Marital Status 12. Was Decedent Ever in U.S.	21784	pecify Ve s or No-	USA 14. Race - Ameri	ican Indian
020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Memtal Hygiene. I them 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It is Medical Evalution of the countries of the countries.	ρ	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ ☒ No If Yes, Give Ye ar or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 ¼ No Specify:</li> </ul>	Rican, etc.)	Black, White,	
	72 hor	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) ((	ecedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	16b	b. Kind of Business/Ir	ndustry
7	within ene. than "	Jup	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)  Homeniaker		Domestic	
2	filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai		
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ָ ט	s 1 and f Heal item 2 other		03.			c. Location - City or T	
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ב ב	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Magnee.	9	21. Signature of Funeral Service Licensee  Buan L. Hauset 1400764	<sup>2</sup> HATGHT Address of Faculty HON PO Box 195 Sykesv		L, P.A.	
			23a. Part 1. Enter the disease, or complication; that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate Interval Between Opset and Death
f	Physician /Medical		resumna in death)	rysema			10 years
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	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of deli	very Day Year
5	at the de by the tached	hysic	1 ☐ Yes 2 Mo 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)			
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E .	sIclan: The certificate h rector, page	Con			performe 1 □ Yes 2	d?   death?	2 🗆 No
>	ding Physician: The h. h. After this certificate h. funeral director, page	) Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☒ No  Hospital: 1 □ Inpatient 2 □ ER/Outp.	Other:	th (Check only one)	ce 6 ☐ Other (Spec	oif d
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2	tendir eath. Ior: Af the fur	catic	2 Accident investigation	M 1 □Yes 2 □No			
2	l or At after d Direct	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.				
	To the within To the Comple	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	n, Day, Year)
			>/uslatus	02/211		8/10/9	7009
			30. Name and address of person who completed cause of death (Item 23a) (T	exetom Gul, En	desbuy	MO	21784
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 18 2009	D27>11 egeton Yvl, En			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death ugust Month 20119 Pau1 Donald Hood Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center GIEN DUTILE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Oct. 24, 1927 Glen Burnie Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F 81 215-20-8906 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2 NNO Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1612 Tieman Drive 21061 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 DXYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mason Masonry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hood Alice Hinners 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Paul D. Hood Jr. /Son 2001 Monumental Road Baltimore MD 21227 August 20, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Glen Haven Mem. Park! Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 M00918 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

End Stage
Chronic Ustructure Pulmidisease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 PNo 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onli one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuar of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed burial-tran P.O. Box 68760, attending physiciar the as ase detached for signed by a Division of Vital Records, has this certificate director, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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Physician/Medical

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Certification: To

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**Funeral** 

Director

show

27 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examinat must be notified at

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, IT along.

**Physician** /Medical

Examiner

Maryland 21215-0036

Baltimore,

29b. Signature and title of certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) August 16, 2009

30. Name and address of person who completed tause of death (Item 23ax (Type, Print) Wus putal Drive, Glen Burnie 3016)

31. Date filed (Month, Day, Year) State 8 Registrar

29a, Certifie



		1	For State Registrar	State o	f Marylan		artment o <i>rtificate d</i>				jiene leg. No.2	09	26282
	E. I.	_	Decedent's Name (First, Middle	, Last)						2. Date of Dea Month		_ Year	3. Time of Death
	Physici /Medic		Michael	Fran	cis		Hieb1	er		August		20009	10;45 AM
J.	Examin		4a. Facility Name (If not institution Stella Maris Ho		mber)		4b. City, Tow	n, or Location Onium	n of Death			y of Death ltimo:	re
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yo		er 24 Hrs. Min.	8. Date of Birth (Month, Day	. Year)	9. Birthp	nlace (State or Foreign
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	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
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	the N 28a-1 notifi	Director	Maryland Balting 10e. Street and Number	nore	טנ	undalk_	10f. Zip Cod	le		1	10g. Citizen of	What Cour	ntry?
	3a or		7615 Merrit	t Road			212	22			U.	S.A.	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Decedent	of Hispanic C	Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americack, White,	
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Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Puneral Service	Licenses/	in his	22	2. Name and A W. Dabr 1005 Du	ddress of Fac OWSKi/ ndalk	Chojr Aveni	acki Fu e Balti	meral	Homes arvla	P.A. nd 21224
8760, ज	Physician /Medical Examiner ithe prival-transit	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a conseq	quence of):	Inca						Interval Between Osset and Death
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	To the within 2.	Medical	one) 29b. Signature and title of certific		nner stated.		29c. L	cense numb	er, ,	2	29d. Date sig	ned (Month	, Day, Year)
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	8x1		30. Name and address of person	who completed car	of death (Iter	m 23a) (Type	Hola	buel	n	~ Bo	U	M6,	21222
	St Regist	ate rar	31. Date filed (Month, Day, Year AUG 18	2009 Per	negistrar's Sign	. pa	de						

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	or Hea		20a. Method of Disposition	20b. Place	of Disposition (Name of etery, crematory or other place		ate	20c. Location - Cit			
	Page ment (		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	7	Lawn_Ecm	i	2009	Baltim	oro Md		
	Dallimore, permit. Pages 1 ar Department of Hea Important: If item; any Injury or other once.		21. Signature of Funeral Service Licensee	TOUR	22. Name and Address Calvin B.	ss of Facility SCTUGG	, 2009 s Fune	ral Hom	e		
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	or vith	2	29b. Signature and title of certifier		29c. License		2	9d. Date signed (M	onth, Day, Year)		
		-	30. Name and address of paragraphic	abb (11		0064261		8 -	10-09		
			30. Name and address of person who completed cause of dea	in (item 23a)	Blace Ra	1 lundar	An K	n Ohingo	MD 21201		
	Stat	.~	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	July 001	V-1/00/1	· · · · · · · · ·	willing	100 010 44		
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	State of Maryland / Department of He 1- For State Certificate of De		628
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Dea	
ledical Examiner	Tracy Anne Ijams	August <del>6,</del> 2009	
	4a. Facility Name (inflormation), give street and hamber/	ty, Town, or Location of Death 4c. County of Death	İ
	St. Agrics (100pital	Iltimore Under 1 Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State of	,
Funeral	o. oca C T T O	onths Days Hours Min. Foreign	1
Director	216-90-6578 1 M 2X F 43 Yrs. M	Feb. 23, 1966 <sup>county)</sup> USA	
y	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside Cit	ty Limits
ow any	MD Baltimore Arbutus	1 Yes 2	. □ No
Maryland 28a-f show 1 at once.	10e. Street and Number	. Zip Code 10g. Citizen of What Country?	
th the Maryland 23a or 28a-f sho notified at ouce.	1262 Locust Ave.	21227 United States	İ
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Mediral Examiner must be notified at ouce To Be Completed by Funeral Director		cedent of Hispanic Origin? ( Specify Yes or No-	ck,
r death with or items 23 must be no	Never Married 2 Married Armed Forces?	pecify Cuban, Mexican, Puerto Rican, etc.)  White, etc.  WHITE	
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2121, 2121, 2uld be fill 1 Mental F marked ic event, d	William S. Ijams  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Ad	Margaret Coolahan dress (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
D 21 should and Me 7 is ma artic ev	- [	Locust Ave. Arbutus, MD 21227	
Tore, MD 2 gges 1 and 2 shoul nt of Health and N t: If item 27 is ur other traumatic	Anthony Cigna, III 1262 1	(Name of cemetery, Date 20c. Location - City or Town, State	
of Her t	Cremation 2 Removal from State crematory or other	ematory, LIC 8-15-2009 Glen Burnie,	MD
Fag Pag Iment Tant:	4 Donation 5 Other Specify: ACCATTLE OF	and Address of Facility A. 1. The	
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 Injury or other traur	21. Signature of Funeral Service Usenso 22. Name 132	and Address of Facility Ambrose Funeral Home, INC Sulphur Spring Road Arbutus, MD 21227	,
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not enter the n	node of dying, such as cardiac or respiratory arrest, shock, or heaft Between O	e interval
/Medical	failure. List only one cause on each line.	lism with complications of therapy Dea	
raminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	I Shi with Complications of the many	
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760 cate b physi	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	23d. Date of delivery  death 3 Ectopic pregnancy Month Day	Year
ox 6876( eath certificate tatending physer or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use as the best or use a	past 12 months?	(Specify)	
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P.O. B that the de med by the detached is	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I. 23e. Did tobacco use contribute to the cause of c	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the law free death.  The first death. After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director.	p	1 Yes 2 ✓ No 3 Probably 4 L	1111111111
ords, w requir	lete	24a. Was an autopsy prior to completion of	cause of
e law e law e has ge 2 s	Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2	No
tal Rection: The certificate ector, page		26 Place of Death (Check only one)	
Vital Rec hysician: The I this certificate I director, page	© 25. Was case referred to friedlical examiner?  No 1 ✓ Yes 2 No  Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3		
ing Ph After ti Suneral	27 Manner of Death 28a, Date of Injury 28b. Time of Injury		
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t Hose 124 ho		d at the time, date and place, and due to the cause(s) and manner as stated. h, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bodical Contification: To Be Completed by Physician/Me	and manner stated.	29c. License number 29d. Date signed (Month, Day, Yea.	ir)
	29b. Signature and title of certifier	O.C.M.E. August 10, 2009	
	O_M_IM	3.5.1111	
K	30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21201	
N	31 Date filed (Months Rev Year) 32 Revistrar's Signature		
Stat Registra	A1115 T P 2000 1	Kel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O& 1:58 AM **Physician** 2009 ber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore washington Anne ArundeL Glen Burnie Med Ctr If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 🕅 M 2 🗆 F 217-62-5808 55 Director Jan.9,1954 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middal Examilian in ust be notified at once. 1 ☐Yes 2 No Director Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 500 Vogts Lane 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 [Yes 2]X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Contractor 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn M. Wilson ဂ Charles R. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debra J. Jones /wife 500 Vogts Lane Baltimore MD 21221 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Holly Hill Cemetery 8/18/09 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Parvi. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (of as a consequence of) The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of page 2 s autopsy perform certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner/ 1 Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 DOA Certification: To 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061907 completed cause of death (Item 23a) (Type, Print) 1124 Mace

Registrar DHMH 17 Rev 1/2001

State

31. Date filed

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene UU 3 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 10:55 A.M 15 2009 James Augustine Judge, Jr. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville
If Under 1 Year If Under 24 Hrs. Baltimore Summit Park Nursing & Rehab 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1⊠M 2□ F Yrs 86 Director 016-18-7669 1922 Oct. 11, Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County than "natural", or items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, It e Medical Examinating must be notified at 1 ☐ Yes 2X No Director Maryland | Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 446 Chalfonte Drive 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Pilot Air Force permit. Pages 1 and 2 silvers. Department of Health and Mental Hygie Department of Health and sarked other throntant: If item 27 is marked other throntant: If item 27 is marked other throntants. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Augustine Judge, Sr. Annetta Burns 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. Isabel Judge Wife 446 Chalfonte Drive; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, Important: If any injury o Atlantic Crematory 8-20-2009 Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville, 21228 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Aurising Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a

To the Funeral 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manyner stated. 29c. License number 29b. Signati 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1009 vederick

State Registrar 31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

32. Registrar's Signature

09-06345 Myuag Yi Kang

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 26287

		- For State	Certifica	ate of Death		Reg. No. 3. Time of Death		
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last)	I KAN	6		2. Date of Death Month Da August 13, 2	009	1517 hrs
		4a. Facility Name (if not institution, give st 8225 Elberta Drive	reet and number)	4b. City, Town	, or Location of Death ity	th 4c. County of Death Howard		
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birt		Year If Under 24Hrs.  Days Hours Min.	8. Date of Birth(N	4 0	country)  With Kong A
w any		Usual Residence of Decedent 10a. State 10b. County 10 How A	2) F 9/ 10c. City, Town ELL	or Location		100	Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
the Maryl or 28a-1 iffied at o	Director	10e. Street and Number 8 2 2 5 E L B	ERTA OR	10f. Zip Co	21044	/ log.	US A	2
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter I file 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	L	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If	2. Was Decedent Ever in U.S. Armed Forces?  Yes 2 No Yes, Give Year Dates:	If Yes, specify C		Rican, etc.)	14. Race - Ame White, etc. Specify:	ASIAN
21215-0036  Uld be filed within 72 hours after de Mental Hygiene.  Manarked other than "natural", or event, the Medical Examiner m	ompleted	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)	Decedent's Usual Oct during most of workin	supation (Give kind of vg life. DO NOT use reti	red) (First, Middle, Mai	DOME	/ 1
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than item 27 is marked other than item 27 is marked other than	To Be Co	17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Typ	e, Print)		Street and Number or	1100	UN/_	ate, Zip Code)
ges 1 and 2 sho to of Health and H. If item 27 is			20b. Place	of Disposition (Name atory or other place)	of cemetery,	Date 2	<u> </u>	or Town, State  MARKAND
Baltimore, permit. Pages I as Department of He Important: If ite		Donation 5 Other Specify:     Signature of Funeral Service License     Part I. Enter the disease, or complice.	Runch 6	22. Name and Ad	Gulfer	or respiratory arres	FUNETO,	Approximate Interval
Physician Medical caminer	- 0	failure. List only one cause on each Immediate Cause (Final disease a. A	ations that caused the death. Both line.  sphyxia by hanging  te to (or as a consequence of):	iot enter the mode of t	ying, saan as salates t			Between Onset and Death
	Examiner	cause. Enter Underlying Cause	ue to (or as a consequence of):					
ecuted and transit		d.	ue to (or as a consequence of):					
ox 68760, ath certificate be ex attending physician or use as the burial	Physician/Medical	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown	AMENDED  23c. If yes, outcome of pregnance  1 Live birth  4 Pregnant at time of death  9 Unknown	y 2 Fetal death 5 Other (Specific	3 Ectopic pregr	nancy	23d. Date of deli Month	very Day Year
i, P.O. Bot ires that the de signed by the lbe detached fi	by Ph		contributing to death but not result	ing in the underlying o	ause given in Part I.		acco use contribute 2 ✓ No 3	e to the cause of death?  Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require range from the law require at other this certificate has been si led in by the funeral director, page 2 should be led in by the funeral director, page 2 should b	Completed					24a. Was ar autops perform 1 Yes 2	y prior ned? deat	e autopsy findings available to completion of cause of h? Yes 2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner?			Di.Place of Death (Chec		2 11 2 2 2	Nhan Casa
of Vit ing Physici After this c	1 -	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury 28	Outpatient 3 DC  D. Time of Injury 28  OO hrs	c. Injury at Work?		Residence 6 Co ow injury occurred ged self	other: Scene
Division  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ,, completely filled in by the fi		1 Natural 5 Pending 2 Accident Investigatio 3 ✓ Suicide 6 Could not b determined	28e Place of Injury - At home	, farm, street, factory,	1 Yes 2 No	or Town St	treet and Number of ate) Drive, Ellicott City	or Rural Route Number, City
Fo the Hospits within 24 hours To the Funers completely fill	\	one) 2 Medical Examiner:	n: To the best of my knowledge, on the basis of examination and/o	death occurred at the	ime, date and place, a opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.		O.C.M.E.			(Month, Day, Year)
		30. Name and address of person who c Zabiullah Ali, M.D. Assis	ompleted cause of death (Item 23stant Medical Examiner	a) 111 Penn Street	, Baltimore, MD 2	21201		
	State		32. Registrar's Signature	had s	<del> </del>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) KYUNGSUK **Physician** AUGUST 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OLNE MOUNTCOM ARY GENERITC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Hours 1**8**-M 2□ F 213-80-1182 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Evantins must be notified at 1 Yes 2 □ No MOUTGOMERC) Director MID 10g. Citizen of What Country? 10e Street and Number HAYLOET 2085 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: ASIAN Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ğ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DEV CLEANERS filed within 7 I Hygiene. College 1-4or 5+) Elementary/Secondary (0-12) USINESS MANI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F IM IONG WOL ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8100 HAYLOFT DR. ROCK-VILLE, MARYLAND 20855 FRANK SHINKANG-SON 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-18-09 OLNEY, MML NORBECK MEMPK 22. Name and Address of Facility flow poly for well them & 21. Signature of Funeral Service Ligenses DZZOGULL FORURO VES Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxi ate Interval Between Onset and Death CHINONEC ADULT RESPERATERY OFITRESS SYNDREIM Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be execute burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed COULEITEUE HEART FASILIRE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗹 No 1 ☐Yes 2 🗷 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 14. 023630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKT. MAYO, MA ILZZE FALAGRICK RA MZIZ GATTHERSBURG, MA

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Morth, Pay Year)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			FOF	Certificate of Death	Reg.	2009 26289
	Physici	an	1. Decedent's Name (First, Middle, Last)	200 MY 2		Day Year 3. Time of Death
-	/Medio	cal	4a. Facility Name (If not institution, give street and number)	4b, City, Town, or Location of Deat	08 th	11 2009 1609 M 4c. County of Death
-	Examin	e i	BALTIMORE WASHINGTON MEDICAL CENTER	Glen Burnie		Anne Arundel
	Funeral Director		5. Social Security Number 216-68-9204 6. Sex 1 □ M 2 N F 54 1 ∨rs	Months Days Hours Min		9. Birthplace (State or Foreign Country) MD
	aryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	e Mary Sa-f sh	ctor	MD Anne Arundel Glen Bu	ırnie		1 □ Yes 2 No
	ath with th	Funeral Director	10e. Street and Number 512 Newfield Road	10f. Zip Code 21061	10g.	Citizen of What Country? USA
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If with Medical Eventing must be notified at once.	þ	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc.  Specify: white
15-(	n 72 h "matu edice	olete	(Specify only highest grade completed) (G	ecedent's Usual Occupation five kind of work done during most of wo fe. DO NOT use retired)	orking	. Kind of Business/Industry
212	d withi giene. sr than	Be Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ırse		State Hospital
pu	be file tal Hy d othe event,		17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	den Surname)
ryla	should ind Mer i marke umatic	은	William Kenny  19a. Informant's Name/Relationship (Type. Print)  19b. M	alling Address (Street and Number or R	ce Filip	ity or Town State 7in Code)
Ma	alth ar 27 is er trau		1 111	College Ave; Stewa		
Baltimore,	Pages 1 annent of He		20a. Method of Disposition 20b. Place of Di	sposition (Name of	Date 200	Location - City or Town, State Len Burnie, MD
Balt	permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Licensee  MUI 3 (0 4	22. Name and Address of Facility Ki 421 Crain Hwy SE G	irkley-Rudd Glen Burnie	ick Funeral Home PA MD 21061
	Physician /Medical		23a. Part 1. Ent. * th. is ase, or complications that cause the death. Do not shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	enter the mode of dying, such as cardia		Interval Between Onset and Death
	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2000 Son		
W	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
68760,	icate be executed physician and the burial-transit		resulting in death) Last			
687	tificate ig phys as the	<b>Jedical</b>	d			
O. Box	requires that the death certificate be executed seen signed by the attending physician and nould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?  2 10 3 Probably 4 Unknown
Vital Records,	The law ate has b	Completed			24a. Was an autopsy performed 1 ∐Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death?  1
Zį.		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Other:	eath (Check only one)	C T Other (O '/')
n of	ding Phys h. After this funeral di	on: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) Inju	e of 28c. Injury at	28d. Describe how i	e 6
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	t and Number or Rural Route Number,
Ö	urs after or ral Dil	Cer			1	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Contified Certifying Physician: To the best of my knowledge, do (Control only 2 Hebical Examiner: On the basis of examination and/one) and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occurred.	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	5 vit	2	29b. Signature and till for dertifier	29c. License number	29d.	Date signed (Month, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Ty)	oe Print)		08/15/100),
_	1,1		«TOPHAN 122, ma 75750 M/40	HIGHWAY GLED	BURON R	washion side
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 18 2009 Since 1. La	Kel		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Year 14 Day **Physician** AUĞÜST ELAINE KOENIGSBERG 11:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE FOREST HAVEN NURSING HOME CATONSVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 08/12/1940 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months 1 □ M 2 🕱 F 69 MD 217-40-5308 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No **Funeral Director** MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 7 SLADE AVENUE or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc 1 ∐Yes 2 MX No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify. Š 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) JEWELRY SALES 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) MORTON COHEN EVELYN **KEISER** ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMA BECKER/SISTER 3621 WOODVALLEY DRIVE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ADATH YESHURUN CEM. 08/16/2009 4 Donation 5 Dother (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1/21No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYSICIAN

.J.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

BALTIMORE

SF

BALTIMORE

mo 21283

1940

\$2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDHU

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ames Kemar 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Himor & If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Country) 215-28-2755 1**0** M 2□ F Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location "natural", or Items 23a or 28a-f show edical Examiner must be notified at Yes 2 No Hore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 USA al Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10/Yes 2 No If Nes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No lokaman Baltimore, Maryland 21215-0036 Specify. Specify: Klac þ 3 ☐ Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ploved Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 □Removal from State 25/09 ()WINGS Forest Sarri Fuxeral 21. Sig At e of Funeral Service Licenses 22. Name and Address of Facility Howell Heights Ralto MD 2120 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. myocardial Immediate Cause (Final acrite Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CAD Sequentially list conditions, if ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Exami DM Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 R/Outpatient 3 DOA 1 | Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 ☐ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MID 0055157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimone breene \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State 18 2000 Registrar

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

AshleypA

31. Date filed (Month, Day, Year)

AUG 18

Helen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eson

32. Registrar's Signature

29c. License number 29d. Date signed (Month, Day, Year)

2009

600 North Wolfe St, Baltimore, MD, 21287

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Marguerite Α. Lumb August 17, 2009 0600 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Co. Genesis Center Hammonds Lane Brooklyn Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1□м 21 г Hours 020-22-7737 82 Director 12, MA April Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinat must be notified at Director 1 ☐ Yes 2 X No Essex Bradford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Modical Examinar must be 1908. 102 South Elm Street 01835 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: Specify: Completed by White 3√Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bostch Hockmouth Marguerite ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 01835 Bradford, MA 102 South Elm St. <u>Mrs. Donna Sutherby</u> / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ridgewood Cemetery Aug. 18,2009 North Andover, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA; 1 2nd Ave SW Glen Burnie, MD 21061 M01121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muscardia /Medical Due to as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \( \sum \text{Yes} \) 2 \( \sum \text{Po} \) Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Records, **Division of Vital** s after death.

I Director: After in by the full within 24 hours after
To the Funeral Directory

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

ddress of person who completed cause of death (Item 23a) (Type, Print)

Opkwood Road Olen Burnie MA 21061 7845 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) D8 **Physician** /Medical Facility Name (If not institution, give street and number) County of Death 4b. City. Town, or Location of Death Examiner heverly George's 8. Date of Birth (Month, Day, **Funeral** 12 M 2□F Min. Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show traumatic event, the Medical Exprenent resist be notified at 1 □Yes 2 🗷 No **Funeral Director** 10g. Citizen of What Country? ō items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government filed 18. Mother's Name (First, Middle, Maiden Surname) Be မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or To In, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health a:
Important: If item 27 is
any Injury or other trau Daughter Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee aux ndallstown, MDZ1133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 Other (specify). 1 ☐ Yes 2 □No signed by the a P.O. 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 2 X No 1 □ Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∭XNo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

AUG 18 2009

DAVIS

GRIFFIN

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) A A A Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 3:15 P.M. 2009 James Paul Libertini City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) St. agnes Himore Health Care If Under 24 Hrs. 8. Date of Birth (Month, Day, June 2, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year! Hours Months 1⊠M 2□ F Maryland 1923 219-18-2859 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2X No Baltimore Catonsville 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21228 719 Maiden Choice Lane HRT43 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Ye ar or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married White 1 ☐Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government General Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Caroline Altomare Edward Libertini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane HRT43; Catonsville, MD 21228 E. J. Libertini Wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park 8/20/2009 Elkridge, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, o complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOUTE MYOCARDIAL INFARCTION hour disease or condition resulting in death) Due to (or as a consequence of): years Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ∃Yes 2 □ No 9 \ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown - CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIMBETES MEZLITUS autopsy 2/DNO 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

022648

900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner physician and s the burial-trans Division of Vital Records, P.O. Box 68760, attending p for use as t been signed by the should be detached has page 2 certificate this

After t death.

Physician

Examiner

**Funeral** 

Director

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traumatic event, the Medical

and 2 should be filed within fealth and Mental Hygiene.
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Department of Health an Important: If Item 27 is many injury or other 2000s.

**Physician** 

/Medical

72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical

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Certification: To

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or Attending To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

Registrar's Signature

Duy Ole mo

e and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G894 8/18/09 JH Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:43 AM LEIBTAG August 15 S. 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Sinai Hospital of Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-31-1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 ☐ M 2 💢 F Yrs. 87 216-36-8752 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Marylan ns 23a or 28a-f sho 28a-f shov 1 Yes 2 □ No **Funeral Director** N/A BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21208 3305 SEVEN MILE LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 7 is marked other than "natural", or iter traumatic event, the Marked Experient 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER NER ISRAEL RABBINICAL COL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Known as: Be Harry COHEN FANNY MILLER မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. GITTE LEIBTAG/DAUGHTER 3305 SEVEN MILE LANE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of 20a. Method of Disposition BOBROTSKER BENEFICIAL 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-16-2009 | ROSEDALE, MD 4 □ Donation 5 □ Other (Specify) ODGE 100-10-2003 1 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2003 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100-2000 2 100 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, and immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Diabetes Mellitus Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours aft the Funeral DI mpletely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D59062 15 2009 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MΔ 21215 2401 W Hansen Belvedere 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 14 2009 Year AUGUST **Physician** 5:45 P KENNETH LIPPEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CASEY HOUSE ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 X M 2 □ F 80 054-20-7477 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Exercises. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director MD MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 USA 1235 POTOMAC VALLEY ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕱 No Specify: Specify: WHITE \$ 3 ☐ Widowed 4 🗶 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NATIONAL INSTITUTE Elementary/Secondary (0-12) College (1-4or 5+) OF HEALTH SCIENTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EVA NIEDELMAN ADOLPH LIPPEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SARA GIBBS/NIECE 2405 COVINGTON ROAD, AKRON, OH 44313 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP.08/17/2009 TOMSON, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Scott 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):
END STAGE DEMENTIA Examiner Sequentially list conditions if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 □Yes 2 No 1 🗆 Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier chou 063748

State Registrar

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Joycelyne 4 1 2 1 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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201 East University Pkwy

Baltimore,MD 21218

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Thomas Alexander	1	ledley - For State Registrar	Stat	te of Maryla		rtment of tificate of		nd Menta	l Hygi	ene Reg	. No.	200	9 2629
Physician	_	Decedent's Name (Fire	st, Middle,I	Last)						Date of Death			3. Time of Death
Medical Examine	er	THOMAS	3	ALEXA	WDER	M	EDIEG	)K	·	Month I Jugust 10,	Day 2009	Year	0556 hrs
		4a. Facility Name (if not 224 Herring Cou		give street and nu	mber)		4b. City, Town, Baltimore	or Location of D	Death		4c. Co	ounty of Death	
Funeral	1	5. Social Security Number	er 6	. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Y	ear If Under 2	24Hrs. 8.	. Date of Birth	(MM/DD/		nplace (State or
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	<u> </u>	11. Marital Status		12. Was Dec	edent Ever in U.	S. 13. Wa	as Decedent of				14.		can Indian, Black,
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Physician	+	23a. Part I. Enter the dis			aused the death.	Do not enter	the mode of dyir	ng, such as card	diac or res	spiratory arres	st, shock,	, or heart	Approximate Interval
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Reflicate	3 -									1 <b>✓</b> Yes 2	No	1 🗸 Ye	es 2 No
ital siciam s certi irector	ŏ	25. Was case referred to examiner?		Hospital:	npatient 2	ER/Outpatien		Other	Nursing H		Pasidance	e 6 🗸 Other	Scana
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Division of Vital Records, P.O. spital or Attending Physician: The law requires that the next Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	5	1 Natural 5	Pendin	g Aug 10,	Day Year) 2009	0535 hrs	1	Yes 2 🗸 N	<sub>lo</sub> Su	bject shot			
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	1	30. Name and address of	Vall	to completed according	a of dooth (ltom	(23a)							
	Щ	Victor Weedn M	מו. מו	Assistant Me			Penn Street	, Baltimore,	MD 21	201			
Stat	е	31. Date filed (Month, Da	y Year)	32 Re	gistrar's Signatu	fe ha	Kel						
Registra	ir	AUG	105	009 <i>Oer</i>	wa p	. your	/						

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	Physici /Medi		1. Decedent's Name (First, Middle, Las	oney					2. Date of Month	Death Da		3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, given Topics Hopkins Bay:  5. Social Security Number  6. S	e street and number)	1 0	t birthday) If I	BACTIME Jnder 1 Year nths Days	If Under 24	eath		Rounty of Dea	
1	death with the Maryland ims 23a or 28a-f show Trust be notified at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, 1 Balt:	fown or Location	า					10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1303 Broening Hid	ghway		10	10f. Zip Code 21224				itizen of What Co	ountry?
9800	72 hours after dea "natural", or items dical Evaning, m	<u>Ş</u>	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □Yes 2 [X] If Yes, Give Year or Dates:			Decedent of H , specify Cuba es 2 🔀 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Am Black, Whit Specify: W	
21215-0036	3 10	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)  (Give life.			Usual Occup of work done o OT use retired offeur	ation during most of f)	working		Kind of Business et Mana	<sub>/Industry</sub> ger Divisio
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nore, Mar	1 and 2 sho Health and em 27 is m ther traum		19a. Informant's Name/Relationship (*David Mahoney/ Sc 20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.  1303 Broening Highway, Baltimore, MD 2122-  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City or Town						.224 Town, State	
4 ☑ Donation 5 □ Other (Specify) Anatomy Gifts Regis  21. Signature of Funeral Service Licensee 22. Name and Adv							ne and Addre	ss of Facility	•	Gifts	•	
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or compands, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events)	a. Due to (or as	ne.   - Ons	Do not enter the LIN SAS Ice of):	mode of dyin		rdiac or respirato			Approximate Interval Between Onset and Death 2 hours
,092	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequen	7010	OBIFU	monal	Byposs			4 pays
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3 🗆 Ecto	opic pregnance er (specify)	у		_	23d. Date of de Month	elivery Day Year
Records, P.	w requires that s been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death b	ut not resultir	ng in the underly	ring cause give	en in Part I.		id tobacco	- 1	o the cause of death?
Vital Rec	ician: The law certificate has b ector, page 2 sl	e Completed	25. Was case referred to medical					OC Place of	24a. V a p 1 □ Ye	utopsy erformed? s 2 No	prior to	utopsy findings available completion of cause of
>	s cer	Be	examiner? 1 <b>2 Y</b> es 2 □ No	Hospital:	O I E D	/Outpatient 3	Othe	Dr1				
Division of	or Attending Physician: ter death. irector: After this certifica in by the funeral director, p	Certification: To	27. Manper of Death Natural C Accident C Suicide C Homicide  2 C Accident C Could not be determined	28a. Date of Inju (Month, Da	y, Year)	b. Time of Injury	28c. Injur Work	y at	28f. Locatio	be how inju	ry occurred	ural Route Number,
Ω	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical Cer	29a. Certifier (Check only one) Certifying Ph	ysician: To the best liner: On the basis o and manner sta	t examination	dge, death occi	urred at the tir pation, in my o	ne, date and p pinion, death o	place, and due to occurred at the ti	the cause (	s) and manner and place, and du	s stated. e to the cause(s)
	To the To the comp	ğ	29b. Signature and title of certifier				29c. License	e number		29d. Da	ate signed (Mon.	th, Day, Year)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier

29c. License number RES-000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER SCIOTTION 4940 32. Registrar's Şignature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16 **Physician** ANCELAR MONTI 2009 08:50  $p^{M}$ 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Baldwin Dulaney Valley Assisted Living If Under 1 Year 8. Date of Birth (Month, Day, Yes 09/21/1912 If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Min Hours Months 1 □ M 2 🗙 F New York 088-16-0263 96 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Department of Health and Mental Hygiens in the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the production of the productin of the production of the production of the production of the pr 1 X Yes 2 □ No Director New York NY New York 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 10016 60 West 57th Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 [X] If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 □Yes 2 🕱 No ò Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Designer Jewelry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Collianni Frank Monti ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Alcott Road, Mahwah, NJ 07430 Thomas Ciofalo, Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ferncliff Mausoleum 08/21/2009 Hartsdale, NY 4 □ Donation 5 ☑ Other (Specify) entombment 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee lletandua 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBLAVASCULA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) icate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 □Yes 2 No 1 ☐Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Asst. Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Aftert 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year) AUG

(Check only one)

30. Name

29b. Signature and title of certifier

M

and address of person who completed cause of the (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔀 🗓 🗓 🕄 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9:20 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Freelan altimore 8. Date of Birth (Month, Day, Year) April 7,1928 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 212-24-1519 1 M 2 □ F Maryland Director 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moderal Eventine. 10c. City, Town or Location 10d. Inside City Limits Director Freeland 1 ☐ Yes 2 → No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21053 by Funeral 21612 Orwig Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 😾 No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Meatcutter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Beeman Fazenbacker ပ္ John Monahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21612 Orwig Road-Freeland, Maryland 21053 19a. Informant's Name/Relationship (Type. Print) Gladys I.Monahan-spouse 20b. Place of Disposition (Name of competery Crematory or other place)
HOLLY HILL Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Aug.20,2009 Middle River, Maryland Gárdens 22. Name and Address of Facility
Evans Funeral Chapel 21. Signature of Funeral Service Licensee 16924 York Road Monkton, Maryland 21111 and Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ance disease or condition resulting in death) 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation eral Director: A 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Recertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8.17.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 60201 un 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1747 PM 2009 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 - M XX 590-70-3283 29 **Director** Sept. 7, 1979 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notified at 1 XYes 2 □ No Director Port St. Lucie Florida St.Lucie 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 0 USA 34984 items 23a 2098 SW Libra Lane Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼★o If Yes, Give 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗙 🗙 o white þ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) the Attorney 12 marked other Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, I once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeanette Louise Olafson Gary Thomas Bowen ပု 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2098 SW Libra Lane, Port St. Lucie, Florida 34984 Gregory Scot McCampbell-spouse 20b. Place of Disposition (Name of cometery, crematory or other place)
Scobee – Combs – Bowden
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State Aug. 20, 2009 Boynton, Florida 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 16924 York Road Evans Funeral Chapel Monkton Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Brainstem compression /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that introduced in the cause (Disease or injury that introduced in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that in the cause of injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Eetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 1 Yes 25 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ပ 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation Natural Accident Injury 1 Tes 2 🗌 No I Director: A 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 John C. Probasio, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical Olivia AVQUST 1942 PM 1avvin SOM 12 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 - M 2 X F Days Hours Min 212-56-7708 SC 60 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City Town or Location er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 No Director Baltimore MD N/A 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21218 2723 The Alameda USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: 14 Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify þ Black 3CWVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) marked other than N/A Disabled yr 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Pages 1 and 2 should be file timent of Health and Mental Hitant: If item 27 is marked out Be John Joseph Harper Geraldine Boyd ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrice Mattison-daughter 2723 The Alameda Baltimore, MD 21218 Department of Heal Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial XXCremation 3 ☐ Removal from State 8/22/09 Baltimore MD4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, MD 21202 and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, loading to an additional cause. Enter Underlying Cause (Disease or injury that initiated events Tau to 6 a law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a Box 68760. attending physician Physician/Medical as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth fo in the past 12 months?
1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the a 9 Unknown this certificate has been signed by 'sral director, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 2 No 3 Probably Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? 2 TNo 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 X Inpatient Other: 4 \sum Nursing Home 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: if or Attending P s after death. Director; After t 1 X Natural (Month, Day Year) Injury 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Spec/fy) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical

Hospitai within 2

State Registrar Benjamin 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

one)

address of person who completed cause of death (Item 23a) (Type, Print) ·1 ders 32. Registrar's Signature

29c. License number

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jesse Alonzo McKnight, Jr. Physician/ Aug. 2009 3:11a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Care Baltimore Towson Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** (Month, Day, 1 ፟ M 2 □ F Months Days Hours Min. 215-52-0695 MD Director 1948 Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD BALTIMORE Randallstown 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ns 23a r / must b 4218 Hanwell Road 21133 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: "natural", Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates er than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12th yrs. McCormick & Company Construction Worker ulth and Mental Hygien 27 is marked other to traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked o any injury or other traumatic eve once. 0 Jesse Alonzo McKnight, Sr. Frances Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Burden - Sister 4218 Hanwell Road, Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 - Other (Specify) 8/19/09 baltimore, Md Mt. Zion 21. Sign tun of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue March Funeral Home Baltimore 23a. Part 1. Enter the disease, or complications that of shock, or heart fature. List only one cause on eac Immediate Cause (Final used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Oncet and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 10 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Convour:

Housewill MD

of person who completed cause of death (Item 23a) (Type, Print)

555W

29c. License number

76 Wson POWN Blud,

2000

Tauron MM 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2009 6:45 P. 14 Juanita L. Matter August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Baltimore 6 Briarwood Road Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Funeral Year) Days Hours Months 1 □ M 2 🔀 F West Virginia June 9, 1923 Director 219-20-7794 86 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 6 Briarwood Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White ģ nd Mental Hygiene. marked other than "natural"; 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 other traumatic event, permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Warren Douglas Bula Gay Hosey ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 839 Hilltop Road; Catonsville, MD 21228 Vickie L. Miller Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 8-19-2009 Marriottsville, MD

22. Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc. 21. Signalure of Funeral Service Licen 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OLUN Cancer **Physician** metastal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die It for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 PNo Month Day 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 200 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 No 1 ☐Yes 2 ☐ No 24 hours after death.

• Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death Injury 5 Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar arole

32. Registrar's Signature

enun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

26307

**Physici** /Medic Examir **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Mulcol Error or ust be rutified at once. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar	II ber.WD	g894 8	72570 Ce	9 11 ertificate of	Death		Reg. No.					
	1. Decedent's Name (First, Midd.	le, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death			
cian lical	JESSICA (	C. MARTIN	1				August	12		11:55 p			
iner	4a. Facility Name (If not institutio	n, give street and nu	mber)		4b. City, Town,	or Location of Death		4c. (	County of Death				
	Patuxent River	Health &	Rehab.	Cente	r Laurel			Pı	rince Ge	eorge's			
	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	y) If Under 1 Year		8. Date of Birt	h ,	9. Birth	place (State or Fore			
r	410-42-6855	1□ M 2√X X	82	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 07/26/	1927	TN	ntry)			
	Usual Residence of Decedent												
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ect		e George	э шай	161	10f. Zip Code		T	10a Citia	zen of What Cou	ntry?			
흡	10e. Street and Number							Tog. Citiz	zen or what cou	nuy:			
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Funeral Director	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13	<ol> <li>Was Decedent of If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- Rican, etc.)	- 1	<ol> <li>Race - Ameri Black, White,</li> </ol>				
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Completed	15. Deceder	nt's Education		16a. Dec	edent's Usual Occu	pation		16b. Kin	nd of Business/In	ndustry			
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E	Lienterial y/occordary (0-12)	College (1 2 Ye	ars	Sec	urity Gua	rd		Univ	versity				
ပ	17. Father's Name (First, Middle,	Last)		1		18. Mother's Nam	ne (First, Middle,	Maiden S	Surname)				
Be	Samual Johnson					Emma Ta	11v 11ma	n					
To Be Completed by Funeral Director		alle (E D. C.)		40h **	Illan Adding (Or	1			Town Chats T	'n Codo'			
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	Beverly Canery	/ daugh				Drive, Ap			estville				
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	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State Nev	w Gra	y Cemeter	y <del>07</del> /21	L/2009	Knox	kville,	TN			
	21. Signature of Euneral Service		ess of Facility n Funeral										
	100	<i>u</i>	/ M007	70	Donaldso	n Funeral ott Avenu	Home, l	A.	Maryland	20707			
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	resulting in death)	Due to	(or as a conseq	uence of):									
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ē	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury												
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	IF FEMALE:	00.1/											
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Physician/	9 ☐ Unknown		· • • • • • • • • • • • • • • • • • • •										
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Be	25. Was case referred to medica examiner?					26. Place of Dea	th (Check only c	ne)					
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Ċ	27. Manner of Death	28a. Date	of Injury oth, Day, Year)	28b. Time Injun		ury at	28d. Describe	how injury	y occurred				
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fic	3 ☐ Suicide 6 ☐ Could	nined   Zoe, Place	of Injury - At he	ome, farm,	street, factory, office					ral Route Number,			
Certification: To	4 ☐ Homicide deterr	build	ing, etc. (Specii	IY)			City or To	wn, State)	)				
	29a. Certifier 1 X X ertifvi	ng Physician: To the	e best of my knr	owledge de	ath occurred at the	time, date and place	and due to the	cause(s)	) and manner as	stated.			
Medical		Examiner: On the b	asis of examina										
led			ner stated.		00-11	and pumba-	Т	204 254	to signed /#4se4	Day Vacel			
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		VIII	14 1	M. C	) D2	4721		Aug	just 13,	2009			
	30. Name and address of persor	who completed cau	se of death (Iter	n 23a) (Typ	e, Print)								
	Syed Sadiq,					Laurel, M	Maryland	20	707				
ate	31. Date filed (Month, Day, Year		Registrar's Signa										
rar		8 2009			Land								
1	Allia	0 /11114   /	Part St. Auch 1	19 1	MI MARKET								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of I	Maryland		artment rtificate			and M		giene Reg. No.	2009	25303
В	Physici	an	1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
d	/Medi			Montague 1							lugust	13,	2009	2:37 P M
	Examir	er	4a. Facility Name (If not institution				4b. City, To			of Death			ounty of Death	
_			Laurel Regi  5. Social Security Number		pital Age (In yrs. la	as t hirthdowl	La If Under 1	ur	e1 If Under 2	24 Hrs	8. Date of Birt			Georges
i.	Funeral Director		051-66-5697	XXM 2□F	50	Yrs.		Days	Hours	Min.	(Month, Da	y, Year)	Cot	nplace (State or Foreign untry)
U			Usual Residence of Decedent								Dec. 2	2,19	og Gu	yana
	yland how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	e Ma	cto	MD Balt	cimore	Ca	atons	vi116	ē						1 □ Yes XXNo
	or 28	Funeral Director	10e. Street and Number				10f. Zip C	Code				10g. Citize	n of What Coi	untry?
	23a ust b	ral	1320 Woodbr	idge Road	l			212	228				Americ	
	er deg tems	nne	11. Marital Status	12. Was Decede Armed Force	es?	S. 13. \	Was Deceder f Yes, specify	nt of Hi y Cuba	ispanic Oriç ın, Mexican	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	- 14	<ol> <li>Race - Amer Black, White</li> </ol>	
36	s afte		1 ☐ Never Married XXMarr 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2 If Yes, Give Year or Date			1□Yes <b>X</b>	XNo	Specify:			3	Specify: B1	lack
٥ ڳ	72 hours after death with the Maryland natural", or Items 23a or 28a-f show ilcal Examiner must be notified at	ed k		t's Education	· ·	16a Decer	ient's Usual (	Occupa	ation		- 1	16b Kin	d of Business/I	nduetry
15	in 72 n "na Medic	plet	(Specify only highes	st grade completed)		(Give	kind of work OO NOT use	done o	during most	t of workir	ng		partme	
21215-0036	d within giene. r than "	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	(	Corre	cti	ona 1	Of	ficer		rrecti	
Ď	e filed within al Hygiene. I <b>other than</b> '	3e C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	Maiden S	urname)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Merital Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	To Be Completed by	Richard M. N					i	Wa1t	eri	ne Ceo	celi	a Bats	son
Nar	2 she nand nand lisma	1	19a. Informant's Name/Relations	•	,	ł							Town, State, Z	
6,	s 1 and 2 of Health a Item 27 is		Herling L. T	rotter-No								<u>.</u>		and 21228
Baltimore,	iges if if ite or of		XXBurial 2 ☐ Cremation		te Ever	emetery, cren	sition (Name natory or oth Memor	or esplac 13	e) <b>1</b>		ate 22 st <del>21</del> ,	20c. Loca	ation - City or 1	Town, State
Ξij	it. Partitue		4 □ Donation 5 □ Other (S 21. Signature of Frin xat Strvice		Gard	dens				200				Maryland
Ba	permit. Pages 1 and Department of Healin Important; If Item 2 any Injury or other once.	T W	John Comi	altiff.		11	.605 Re	eis	terst	own ]	Road, C	wing	_	e1, P.A. s, MD 21117
В			Shock, or neart failure. List	complications that caus only one cause on each	sed the death. n line.	. Do not ente	er the mode	of dying	g, such as	cardiac o	r respiratory a	rest,		Approximate Interval Between
q	Physician		Imm diate Cause (Final disease or condition resulting in death)	_a Pulmona	ary Ede	ema							- 1	Onset and Death 60 Months
1	/Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):								
2-		7.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or	as a conseque	ence of):								
8.	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	\$ 500.0	ao a concequ	01100 017.							3	
30	execunand and ial-tra	Exal	resulting in death) Last	C. Due to (or a	as a conseque	ence of):					<del>.</del>			
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical		d										
Ö	tificate ig physias the	edi												
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne pf pregnan		Ectopic preg	Topo.				23	d. Date of deli	very
	ed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of dea		Other (spec						Month	Day Year
P. 0	that the denet by the a	Phy	9 ☐ Unknown											
	ires tha signed d be def	ρ	Part II. Other significant condition	ons contributing to death	t but not resul	ting in the ur	derlying cau	se give	en in Part I.					the cause of death?
Orc	w requir been s should	ted							_		101	res 2∐	No 3 ☐ Pro	obably 4XXJnknown
Records,	has the second	Completed									24a. Was autop	sv	prior to c	topsy findings available ompletion of cause of
	iclan: The l certificate ha ector, page										1 Yes	rmed?	death? 1 □ Yes	<b>XX</b> No
Vita	nysician: nis certifica director, I	Be	25. Was case referred to medical examiner? 1XXYes 2 No	Hospital:	VV			Othe	ar.		(Check only o			
Division or	Attending Physician: r death. ector: After this certifics by the funeral director, is	2	27. Manner of Death	1 ☐ Inpa		R/Outpatien			4 ⊔ Nur		ne 5 Resid		Other (Spec	sify)
on	ndlng Ph th. : After thi e funeral	ţi	XX Natural 5 Pending 2 Accident investig		Day Year)	Injury	M	lnjury Work 1 □ Y	:? /es 2 □ N			,,		
N N	or Attendater death	ifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined   26e. Place of	injury - At hon	ne, farm, stre	eet, factory, c	office	1	2			Number or Ru	ral Route Number,
	s afte	Certification:	4 _ Horniordo	building,	etc. (Specify)	,					City or Tou	vn, State)		
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one) XX Certifyin 2 Medical	g Physician: To the be Examiner: On the basis and manner		rledge, death on and/or inv	occurred at estigation, ir	the tim	ne, date and pinion, deat	d place, a th occurre	nd due to the ed at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1			29c. L	icense	number			29d. Date	signed (Month	, Day, Year)
			•	X V	KND			D60	6945	-		Aua	ust 13,	2009
	1.	-	30. Name and address of person		f death (Item 2		Print)							
	Q		Scott Allen Car				isen Ro	oad	, Lau	rel,	Mary1a	and 2	0707	
· g	Sta Registr		31. Date filed (Month, Day, Year) AUG 182	009 Pentu	strar's Signatu	for	elas							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7°5, August 9:50 A M 2009 Glen Michael Orndorff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 D F Days Hours (Month, Day, Year) July 21 Months 214-90-8077 Director . 1958 Hawaii Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Street MD Harford 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21154 USA 1397 Macton Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 ☐ Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Speciarhite "natural", 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Security Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wallace Orndorff Jeanne Groft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Hagan-sister 1397 Macton Road-Street, Maryland 21154 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other pla Gardens Of Faith 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug.18,2009 Rosedale, Maryland 3 Newport Drive 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Chapel remation Services Forest Hill,MD 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) physician at the burial-t Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Division of Vital Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law
 24 hours after death.
 Funeral Director: After this certificate has b autopsy Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 3.0 No Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WSpice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 2 Accider
3 Suicide Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death surred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 8/15/2000 George Hennaur

Registrar

X

31. Date filed (Month, Day, Year)

Orndorff, Glen

Towsontown

BWd

10WSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555

32. Registrar's Signature

W

	1	For State of W	laryland / l	Depai <i>Cert</i>	rtment of Hea rificate of De	eath	R	eg. No.	009	26310
	1.	Decedent's Name (First, Middle, Last)					Date of Dea Month	Day	Year	3. Time of Death  11:11 P.M
Physician /Medical		Mildred Marie Peper			4b. City, Town, or Lo		gust	15, 2	inty of Death	II;II F.
Examiner	48	a. Facility Name (If not institution, give street and number 1725 Morse Road	r)		Forest Hi			Harf	ord	
Funeral	- 1 -	Social Security Number 6. Sex 7. A	ige (In yrs. last b.	irthday) Yrs.	If Under 1 Year   If		Date of Birtl (Month, Day	Year) 1914	Cou	place (State or Foreign ntry) land
Director		220-24-6062								10d. Inside City Limits
yland		0a. State 10b. County	10c. City, Tov							1 □Yes 2X No
or 28a-f st		Maryland Harford	For	est I	Hill 10f. Zip Code			10g. Citizen	of What Cou	intry?
with the		0e. Street and Number			21050		τ	Jnited	State	es
fter death w r items 23a iirur must	1	1725 Morse Road  1. Marital Status  12. Was Deceder	nt Ever in U.S.	13. V	Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Speci	fy Yes or No	. 14.	Race - Amer Black, White	ican Indian, etc.
rs after de		1. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ₹  If Yes, Give  Year or Date:	s? ⊈No			Specify:		Sp	<sub>ecify:</sub> Whi	
partition (e), Intally facing 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modert Examinational percentage once.  To Bo Completed by Finneral Director		15. Decedent's Education (Specify only highest grade completed)	16	ia. Deced (Give life. L	lent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of working		16b. Kind	of Business/l	ndustry
within ene.		Elementary/Secondary (0-12) College (1-40	H H	omem	aker				n Home	
filed of filed of tal Hygin and other event, in		17. Father's Name (First, Middle, Last)				8. Mother's Name ( Martha Mi)				
Vialing Wuld be file Mental H arked ott attic even		Henry John Betz, Sr.							_	Zim Codo)
aly shou and h s mar		19a. Informant's Name/Relationship (Type. Print)			ng Address (Street an					
and 2 and 2 ealth n 27 i		David Peper / Son			Morse Road		HILL,	20c. Loca	tion - City or	Town, State
ges 1 strong from the first of the or oth		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □ Removal from Sta			sition (Name of natory or other place) <b>Cemetery</b>	1		Da sales se	:110 1	Maryland
SAILITHOT Dermit. Pages Department of mportant: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify)	Palkw							ice-Bel Air
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Physician cate be executed by sician and the burial-transit the burial-transit.	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	liac a	ce of):	art fa Uation.					Onset and Death
876 cate l	dical	d	,,,,,,,							
BOX 6 ath certifi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 4 Pregnant 1 Yes 2 No 9 Unknow	ome of pregnancy th 2 Fetal de ant at time of dear wn	eath 3	☐ Ectopic pregnancy ☐ Other (specify)			20	3d. Date of de Month	olivery Day Year
ds, P.O. I	by Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to dea	th but not resultin	ng in the	underlying cause give	n in Part I.			e contribute f	to the cause of death?  Probably 4 Unknown
ecord law requir nas been s	Completed						per	opsy formed?	prior to death?	autopsy findings available completion of cause of
The						26. Place of Death		2 No	1∐Ye	s 2 No
Vita sician certifi rector	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Ir	patient 2 EF	3/Outpati	ent 3 DOA Othe				☐Other (Sp	ecify)
Phys rthis	1: To	27 Mapper of Death 28a, Date of	f Injury 2	8b. Time Injury	of 28c. Injury		28d. Describ			
Division of Vital Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	of Injury - At hom g, etc. (Specify)			Yes 2 □No	28f. Location City or 7	(Street and own, State)	d Number or i	Rural Route Number,
Hospita 4 hours Funeral	Medical Cer	29a. Certifier 1 Certifying Physician: To the property one) 2 Medical Examiner: On the property one	isis of examination	edge, de on and/or	ath occurred at the tir investigation, in my o	me, date and place, ppinion, death occur	and due to t red at the tim	he cause(s) ne, date and	and manner place, and d	as stated. ue to the cause(s)
To the I within 2 To the I comple:	Med	29b. Signature and title of Setting	5		29c. Licens					nth, Day, Year)
F 3 F 8		18410	Parekh.	MD	Dook	8424		Aug	. 17	2009
$\mathcal{Z}_{\mathcal{O}}$		30 riame and address of person who completed caus 1.908 Hav fird Roa	e of death (Item 2	23a) (Typ	e, Print) MD	8424 21047	,			
Sta Registr			egistrar's Signatu	ire	barker					

DHMH 17 Rev 1/2001

P	hys	ici	an
	/Me	dic	al
	Exar	nin	er

Funera Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physiciar /Medica Examine

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

1	For State Registrar		Otate of IV	iaiyiaii	d / Depa <i>Cei</i>	tificat				entarriy	Reg. N	7 11 11	9	2631	
	1. Decedent's Name (First, I	Middle, Last)								2. Date of De	eath		Voca	3. Time of Death	
	Pootee	Sharm	a Pers	aud						Month	150		Year	6:25F	
1	4a. Facility Name (If not insti					4b. City,	Town, or	Location	of Death		4	c. County o	of Death		
į	Manor Ca	re -R	uxton			Ва	alti	more	2			]	Balt	imore	
1	5. Social Security Number	6. Sex	_		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	av. Year	r)		ace (State or Fore	
	215-11-288	ь —	M 2XF	77	7 Yrs.		Dayo			May	17,	1932		"Guyana	
-	Usual Residence of Deceder 10a. State 10b. Co			100 City	y, Town or Lo	cation							10	d. Inside City Lin	
		ltimo	ro	100.010	Essex								,,,	1 ☐ Yes 2 <b>X</b> ☐	
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	10e. Street and Number 1031 Deb	hio A				10f. Zip		2422	24			itizen of W	nat Count	ry r	
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MD Baltimore Essex    10e. Street and Number								0-		, White, e					
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	Elementary/Secondary (0- 9th	12)	Coilege (1-4o	r 5+)	Home	emake	er				10	wn ho	ome		
1	17. Father's Name (First, Mi	ddle, Last)			1			18. Moth	er's Name	(First, Middle	, Maide	n Surname	9)		
	Manisoch	Shar	ma					Ja	asoda	a Sing	gh				
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta											State. Zip	Code)			
	Nonadia D			hter	1	_				d Balt				1221	
-	20a. Method of Disposition		, adday	20h P	lace of Disno	sition (Nar	ne of			ate	· -	Location - (		<del></del>	
	1 ☐ Burial 2 ☐ Crema		moval from Stat	e Ba	emetery, crer	natory or c 7	emat emat	orv.	8/19	9/09	Ba	altin	nore	MD	
4 Donation 5 Other (Specify)  21. Signature of Tuneral Service Licensee															
22. Name and Address of Pacinity 300 Mace Ave. B  Connelly Funeral Home of Es  23a. Part: Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,															
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b.		as a consequence as a consequence											
	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 ₱ No 9 □ Unknown	IL	ic. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic p						23d. Date Mor	e of delive	ry Day Year	
	Part II. Other significant co	nditions conf	tributing to death	but not resi	ulting in the u	nderlying c	ause give	en in Part	l.				ibute to th 3 ☐ Prob	e cause of death	
										-		_			
										24a. Wa: auto peri 1∐ Yes	s an opsy formed?	. d	rior to con leath?	osy findings avail npletion of cause 252No	
-	25. Was case referred to me examiner?	edical						26. Plac	e of Death	(Check only	one)				
	1 ☐ Yes 2 NONo	Ho	ospital: 1	tient 2 🗆	ER/Outpatier	nt 3 DC	Othe	er: 4 <b>154</b> N	ursing Hor	me 5□Res	sidence	6 □Othe	er (Specify	)	
ĺ	27. Manner of Death 1 ∰Natural 5 □ P	ending	28a. Date of Ir (Month, L	njury Day Year)	28b. Time o Injury	f 2	28c. Injury Work	/ at	2	28d. Describe	how inj	ury occurre	ed		
	2 Accident in	vestigation				М		Yes 2□	]No						
		ould not be etermined	28e. Place of i building,	njury - At ho etc. <i>(Specif</i>	ome, farm, str	eet, factor	y, office		2	28f. Location City or To			er or Rurai	Route Number,	
L															
			ician: To the best er: On the basis and manner	of examina											
1	29b. Signature and title of co	ertifier	1	11		290	c. License	number			29d. E	ate signed	Month, I	Day, Year)	
	12-	7- /	Kre	Cel	20.	1	toc	55	446	24	8	-1	7-	09 1225	
-		- //		- 2					-				4	(	
	30. Name and address of pe	erson who cor	npleted cause of	death (Item	23a) (Type.	Print)									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 

Output

Department of Health and Mental Hygiene Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last **Physician** OWEL +ua/Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Nursing Genesis Home +bert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 07 25 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Se **Funeral** Days Months Hours Min 6.48.0370 NC 1**X**M 2□ F Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City Town or Location r 28a-f show notified at Baltimore) Keisterstown 1 ☐ Yes 2 No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 14 Mainbrook USA 21136 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or items 2 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 □ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) united States Elementary/Secondary (0-12) College (1-4or 5+) Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Be Martha ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Court eisterstown MD 21136 of Health a acklyn Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 Department of Important: If It any injury or o 1 Burial 2 □ Cremation 3 Removal from State Windsor Mill, MD 20/09 Park Cemeteri 4 ☐ Donation 5 ☐ Other (Specify) C. Greene Funeral SUCS 21. Signature of Funeral Service License 8 andallstown MD21133 Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as gardiac or respiratory arrest, shock, or heart failure. List only one cause in each linu. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. darring Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the the as attending IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 I Inknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy 2 ☐ No 1 ☐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ٩ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Ceath 28a. Date of lefun. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Accident 5 Pending investigation within 24 hours after common to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 × ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifie 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

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-06383 ark Jason Ros	ario	Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and	All Copies Are Legib Mental Hygiene	le. 2009 2631						
		For State Certificate of Death	Reg. N	3. Time of Death						
Physicia edical Exami	ın/ T	Decedent's Name (First, Middle,Last)  Mark Jason Rosario	2. Date of Death Month Da August 14, 20	1624 hrs						
Edical Exami		a. Facility Name (if not institution, give street and number) 49534 Cornfield Road 4b. City, Town, or L Scottland		4c. County of Death St. Mary's						
Funeral		i. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months   Days		MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary Land						
Director		216-92-3936   1 Mm 2 F   39   Yrs.   Months Days	09/11/1							
nd show any ce.		MD Prince Georges 10c. City, Town or Location Upper Marlboro	)	10d. Inside City Limits 1 Yes 2 X No						
with the Maryland ms 23a or 28a-f show be notified at once.	Director	106. Street and Number 10f. Zip Code 2077		Citizen of What Country? U.S.A.						
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers, or items 23a or 28a-fahe tranmatic event, the Medical Examiner must be notified at once		2105 Gadderf 13 Was Decedent Ever in LLS 13 Was Decedent of His	panic Origin? ( Specify Yes or No- n, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Pacific Specify: Islander						
irs after d ural", or	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No or Dates: or Dates: 16 Decedent's Usual Occupat	bwed 4 Divorced If Yes, Give Year or Dates.  1 Yes 2 X No specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify:							
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21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, th. M. dica		17. Father's Name (First, Middle, Last)  Arnulfo Sison Rosario	18.Mother's Name (First, Middle, Mai Carol Young	den Surname)						
D 21215-003: should be filed with and Mental Hygiene 77 is marked other the matic event, the Media	To Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street	et and Number or Rural Route Number ont Drive, Owings							
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of ce		20c. Location - City or Town, State						
P. P. P. P. P. P. P. P. P. P. P. P. P. P		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  Archert Cremation Service Licensee  22. Name and Address	vices 08/18/2009 s of Facility Ardent Cre	<u>Hanover, Maryland</u> mation Services						
Balt permit. Depart Impor		Louis C. Hardesty Mo 1197 7522 Contr	nelley Drive, Ste	.N, Hanover, MD 2107						
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.  Immediate Cause (Final disease a. Contact Gunshot Wound of Head	, such as calculated respiratory arres	Between Onset and Death						
taminer		or condition resulting in death)  Due to (or as a consequence of):								
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
uted Id ransit	Exan	events resulting in death) Last Due to (or as a consequence or).	//NO 100							
re exec cian ar	dica	UNPENDED X AMENDED 28f, per ME g894 8/18	709 11							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Function: After this certificate has been signed by the attending physician and the control Director. And the this certificate has been signed by the attending physician and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	Physician/Medica	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy	23d. Date of delivery  Month Day Year						
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ires that signed b	d by		1 Yes	2 ✓ No 3 Probably 4 Unknown  n 24b. Were autopsy findings availab						
ecords he law requate has beer	omplete	autopsy prior to death?  1 ✓ Yes 2 No 1 ✓								
an: T ertifica	Be	25. Was case referred to medical	ce of Death (Check only one)	Other Coope						
of Vita g Physici fter this o	- To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. In		Residence 6 • Other: Scene						
Sion ( Attendin death ector: A	catior	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office	Yes 2 No e building, etc. 28f. Location (S	street and Number of Bural Fourte Number, Cr						
Division To the Hospital or Attend within 24 hours after death To the Finneral Director:		Suicide determined (Specify) Fishing Pier	49534 Comfic	e(s) and manner as stated.						
To the II. within 24 To the Fi	Medical	(Check only one)  2  Certifying Physician: To the best of my knowledge, death occurred at the time, one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated.	ion, death occurred at the time, date of	and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)						
<b>1</b>	¥ e	29c. License number 29d. Date signature and title of certifier  29d. Date signature  O.C.M.E.  August 15,								
3	Ì	30. Name and address of person who completed cause of death (Item 23a)								

State Registrar

32. Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar			of Death		eg. No.2009	26314
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death	Day Year	3. Time of Death 9 8:00 A M
	/Medic	cal	Anna A. Rome  4a. Facility Name (If not institution, give			4b. City. To	wn, or Location of Death	August	15, 200 4c. County of De	
	Examir	ier	Stella Maris			-	imonium		Baltim	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. Social Security Number 1 6. S	ex 7. Age (	(In yrs. last birthday) 69 Yrs.	If Under 1 Months D		8. Date of Birth (Month, Day, Jan. 22	, 1940 Ma	irthplace (State or Foreign Country) ryland
	and		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show I must be notified at	tor	MD Baltin		-	Parkv	ille			1 □Yes 2√∏No
	th the	Director	10e. Street and Number			10f. Zip Co	ode	11	0g. Citizen of What 0	Country?
	ath wi	ral	7908 Bonair				21234		USA	
_	ter de items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No	er in U.S. 13. \	Vas Deceden f Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
a。画。	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	l□Yes 2x	No Specify:		Specify: N	hite
	within 72 hours after lene. than "natural", or ite	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	dent's Usual C kind of work o	Occupation done during most of work retired)	ing	16b. Kind of Busines	
8:00	within iene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)			consultant		Rent	al
	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	,		
2009	allyland a should be filed and Mental Hyg s marked other tumatic event, I	2	Guerrino Sti					na Mizz		
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15	s 1 and 3 Health Item 27 other tr		20a. Method of Disposition		20h Diana of Diana	oition /Alama	of .	Data	20c. Location - City of	
AUGUST 15	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Evans F and Crema	unera tion E	l Chapel LelAir Aug.	192009		ill,Maryland
AUG	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	ne tools	Ě	Name and Avans Fi	Address of Facility Uneral Chape Emation Serv	el 8800 vices Pa	O Harford arkville,N	Road 1D 21234
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	e death. Do not ent	er the mode o	of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LUNG CAN						Oliset and Death
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		Medical	IF FEMALE:							
200	The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at till 9 ☐ Unknown	☐ Fetal death 3 ☐	Ectopic prec Other (spec			23d. Date of o Month	elivery Day Year
	uires that the de signed by the a	by Ph	Part II. Other significant conditions of	ontributing to death but i	not resulting in the ur	nderlying caus	se given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
EO	een sig	ted t						1 □ Ye	es 2 No 3	Probably 4X Unknown
ROMEO	The law require rate has been sipage 2 should b	Completed						24a. Was ai autops perforn 1 □ Yes 2	ned?   death	autopsy findings available o completion of cause of ?
ANNA	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat			
7 7	ding Physician: The I h. After this certificate h funeral director, page	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day, )	2 ER/Outpatien 28b. Time of		4 ☐ Nursing Ho		ence 6X Other (Spow injury occurred	pecify) HOSPICE
	ath.	atio	1 Natural 5 Pending 2 Accident investigation		<i>(ear)</i> Injury	М	Work? 1 ☐ Yes 2 ☐ No			
Divioion	Hospital or Attenc 24 hours after death Funeral Director: letely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farm, stre (Specify)	eet, factory, o	ffice	28f. Location (St City or Town		Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	Medical (	29a. Certifier  (Check only 2 Medical Examone) X Nurse Pract	iner: On the basis of e	xamination and/or in	occurred at vestigation, in	the time, date and place my opinion, death occur	, and due to the c rred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	//			icense number	2	9d. Date signed (Mo	nth, Day, Year)
							150259		0117	109
	3		30. Name and address of person who		th (Item 23a) (Type, I		) <u> </u>	4, MD 210	กดุว	
	Sta	_	31 Date filed (Month Day, Year)	32. Registrar's	Signature				V 1 J	
	Registr	ar	AUG 10	MILLY PLEASE	un p.	your				

	4	_ State	Maryland /		artment of H		nd Men		iene	100	00215	
Physician		Registrar     Decedent's Name (First, Middle, Last)     Sherman Edward Riley			ineate of L			Date of Deat		n9 <sup>Year</sup>	3. Time of Death 7:55 PM M	
/Medical Examiner		4a. Facility Name (If not institution, give street and number Dove House 292 Stoner Ave	er) enue		4b. City, Town, or Westmins			guse	4c. Count	ty of Death		
Funeral Director		040 40 0307 XXM 205	Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth (Month, Day,	Year) 1921		place (State or Foreign Intry) Land	
show ed at		Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll	10c. City, Tov		cation ostead		_				10d. Inside City Limits  XXYes 2 □ No	
with the Mar	200	10e. Street and Number  1102 Main Street			10f. Zip Code	1074		1	0g. Citizen of	f What Cou	intry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.  To Re Commission by Firnaral Director	5	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  12. Was Decede Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force Armed Force A	s? ⊒ No	i	Was Decedent of H If Yes, specify Cube		in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Ra Bl	14. Race - American Indian, Black, White, etc. Specify: White		
ed within 72 houygiene. Inter than "natura".  t, the "ledical E	palalino	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-46)	16a	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired NOUSE Man	during most d)	of working	4	16b. Kind of I		ewing Co.	
2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the To Re Comm	מ	17. Father's Name (First, Middle, Last)  John Riley				Cora	Stewa	rd	Maiden Surna			
t and 2 sho Health and item 27 is me when traums		19a. Informant's Name/Relationship (Type. Print)  Craig Riley Son	4	222			sville	Road,	, Hamp	stead	, MD 21074	
Pages 1 Iment of H tant: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta  4 ☐ Donation 5 ☐ Other (Specify)	cemet	ery, crei lens	osition (Name of matory or other place of Faith	. 8,	Date /17/20	09 I		ton,	Maryland	
permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licenses  Alexan			Name and Addre Burgee—He 3631 Fall	s Road	d, Bal	timore	e, Mar	, Inc yland	·	
Physician /Medical		23a, Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death)  a. Due to (or	es a consequence	l	er the mode of dylr	ng, such es	cardiac or re	spiratory arr	esi,		Approximate Interval Between Onset and Death	
cate be executed by sician and the burial-transit of dical Examiner	נ	cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence	21	Hea	n	liova	Scul	ey Di	Sea.	70 da	
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w requires that the de should be detached	3	Part II. Other significant conditions contributing to deat	h but not resulting	in the u	nderlying cause giv	en in Part I.		23e. Did to	_/	_	the cause of death?	
The law requir	analdina						- [	24a. Was a autops perfori	sy ]	prior to death?	topsy findings available completion of cause of	
cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian: cian:	D	25. Was case referred to medical examiner?					of Death (C	1 □Yes heck only on		1 103	11	
Physic rthis o	2		atient 2 ☐ ER/0 Injury 28b	Outpatie Time o		4 LI NUI			ence 6 🗹 C		city) HOSPICE	
To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	III Cation	1 ☐ Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day, Year)	Injury	Wor	ki?  Yes 2⊡N	No		treet and Nur		ral Route Number,	
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	- 1	29a. Certifier (Check only 2 Medical Examiner: On the base)	est of my knowled	ge, dea	th occurred at the ti	me, date an	d place, and	due to the o	cause(s) and	manner as	s stated. to the cause(s)	
To the Hosp within 24 hou To the Fune completely fi	INICAL	29b. Signature and title of certifier	stated.									
		30. Name and address of person who completed cause	of death (Item 23a	) (Type	Print)	100	100	A C.	1-8	inste	7 MD 2117	
State		2 H 17 KA CHED U N / 31. Date filed (Month, Day, Year) 32. 1969	FG A N	N	AMD.700 7	7 Ifec	Le L	4				

Registrar DHMH 17 Rev 1/2001

State

AUG 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year AM ABRAHAM Avaust 2009 6:50 RETTER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Battimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | 04 - 16 - 19 Hospital of 5. Social Security Number 6. S*e*x 1 **X** M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign AUSTRIA 076-26-2028 86 04-16-1923 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3041 FALLSTAFF ROAD #403 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CANDY MANUFACTURING MECHANIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RETTER FRIEDMAN LEIB LEAH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIKA RETTER/WIFE 3041 FALLSTAFF ROAD #403, BALTIMORE, MD 21209 20b. Place of Disposition (Name of BETH JACOBOTANSHE Place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-16-2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) VESHEAR CEMETERY 22. Name and Address of Facility SOL LEVINSON & BROTHERS Signature of Funeral Service Licenses INC. Not 11 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ionaest leav-3 disease or condition resulting in death) as a consequence of): ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant nown

**Examiner** or Attending Physician: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760 the as ned by the a detached for sign be

Examiner an/Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

1 and 2 should be filed within Health and Mental Hygiene.

permit. Pages 1 and 3 Department of Health

Important: If it any injury or o once.

**Physician** 

/Medical

Baltimore, Maryland

Umoun]

is marked other than

Funeral Director

Be Completed by

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within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Hospital

Iysicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death 9 Unknown	Month Day Year
ed by FI	1	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkn
כסווויסופר	on chronic re	enal tailure, chostridium di Cicile	24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause death? 1 □ Yes 2 □ No
מ	25. Was case referred to medical examiner?	26. Place of Death (C	theck only one)
2	1 Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
alloll.	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not 6 4 ☐ Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
Cal		hysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred	

29c. License number

000

29d. Date signed (Month, Day, Year)

August 15, 2009

State Registrar

18

Pratt

29b. Signature and title of certifier

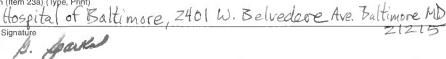
Marina

31. Date filed (Month, Day,



Sival

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #22 per FD G894 8/18/09 TT

Amend #22 per FD G894 8/18/09 TT

Amend #22 per FD G894 8/18/09 TT

Amend #22 per FD G894 8/18/09 TT

				State Registrar	aryland		partment of F ertificate of L		F	Reg. No.)	25317	
	П	Physician		1. Decedent's Name (First, Middle, Last)  ROBERT MATTHEW REA SR.	2. Date of Dea Month AUGUST	10, 2009 Year	3. Time of Death 10:22p M					
	4.	/Medio Examir		4a. Facility Name (If not institution, give street and number GILCHRIST HOSPICE CENTER	)		4b. City, Town, or TOWSON			4c. County of Dea	ith	
		Funeral Director		224-26-1173 1 <sup>1</sup>	ge (In yrs. Ia	ast birthda Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 2-19-1	9. Bi (1. 926 ALA	rthplace (State or Foreign ountry) BAMA	
		death with the Maryland rms 23a or 28a-f show rreust be nutified at	_	Usual Residence of Decedent  10a. State  10b. County		10d. Inside City Limits 1 X Yes 2 □ No						
		the Ma	recto	MD N/A BALTIMORE  10e. Street and Number 10f. Zip Code 10g. 0							ountry?	
		th with 23a or	al Di	6001 BAYWOOD AVE.			21209			USA	· · · · · · · · · · · · · · · · · ·	
	980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wadical Ever it at a use to notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Arrived Forces' 12. Was Decedent Arrived Forces' 12. Was Decedent Arrived Forces' 12. Was Decedent Arrived Forces' 12. Was Decedent Arrived Forces'	?? If Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 🛣 No Specify:				pecify Yes or No- o Rican, etc.)	Consider		
	15-0	72 ho "natur	etec	15. Decedent's Education (Specify only highest grade completed)		16a. De (Gi	cedent's Usual Occup	ation during most of wor	king	16b. Kind of Business	/Industry	
	121	within iene. <b>than</b>	Completed by	Elementary/Secondary (0-12) College (1-4or -0-	life DO NOT use retired)							
	Maryland 21215-0036	ld be filed ental Hygi ked other ic event, II	To Be C	17. Father's Name (First, Middle, Last) EDWARD B. REA	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle,							
2	lary	2 shou and N is ma	_	19a. Informant's Name/Relationship (Type. Print)		19b. Ma	ailing Address (Street	and Number or Ri	ıral Route Numbe	er, City or Town, State,	Zip Code)	
م ا		t and Health em 27 ther tr		MAZIE O. REA (DAUGHTER)  20a. Method of Disposition	20h Pi		1 BAYWOOD sposition (Name of rrematory or other place		TIMORE,	MARYLAND 21209 20c. Location - City or Town, State		
(0:22	altimore,	t. Pages triment of H rtant: if ite		1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	OWINGS MI	OWINGS MILLS, MARYLAN						
_	Ba	Depa impo any ir		21. Signatur, JEuro Service Acense JONATHAN	VD. H						<del>, P.A.</del> ŸLAND 21217	
•		Physician /Medical Examiner		Due to (or as	MIC	Do not	enter the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death	
		ed sit	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.	з а попвады	iones of):						
2009	68760,	rificate be executed ng physician end as the burial-transit	edical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last  C	as a consequence of):							
ust 10,	O. Box 68	requires that the death certific been signed by the attending p hould be detached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	23d. Date of do	Blivery Day Year					
August	rds, P.	w requires that s been signed b should be deta		Part II. Other significant conditions contributing to death OHLONIC KIONEM DISE		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 🛣 Unknown						
	Record	law as b	Completed by	COPENARY ARTERY DISE					24a. Was a autop perfor	med?   death?	utopsy findings available completion of cause of	
t	Vital	ysician: The lis certificate hi director, page	Be C	25. Was case referred to medical examiner?					1 ☐ Yes ath (Check only o		5 2 100	
à	oţ	Physician: r this certific ral director, I	၉	Hospital:		ER/Outpat	tient 3 DOA Other	4 Li Nursing F		lence 6 NOther (Sp	ecify) HOSPICE	
2	ision	Attending r death. sctor: After by the fune	ation	1 Natural 5 Pending (Month, D. 2 Accident investigation	low injury occurred	jury occurred						
2	Divis	al or Attend s after death il Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)								
Rec		To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the besi and manner s	of examinati	wledge, de ion and/o	eath occurred at the tir r investigation, in my o	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and du	as stated. le to the cause(s)	
		To the within To the comple	Ž	29b. Signature and title of certifier	7		29c. License			29d. Date signed (Mor	th, Day, Year)	
				30. Name and address of person who completed cause of	death /ltor	230)/5-	D4	7545	/	angust 1	i, way	
11				DANIEUE DEBERMAN. MD	670	/ N	MAPLES	ST, 81	418 410	5 BALTIMA	PE, MS 21204	
		Sta Registr	_	BUO 1 9 anno	irars Signati	ure .	pare					

DHMH 17 Rev 1/2001

August 10, 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WILLIAM M. REID 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death N/A BALTIMORE BALTIMORE INAI MOJPITAL If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9-27-1924 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1<del>X</del> M 2□ F VIRGINIA 224-34-2238 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director HOWARD MD. COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 6138 MAJORS LANE 21045 USA or items 23a death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1. Tyes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2√2 No þ Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than? Elementary/Secondary (0-12) College (1-4or 5+) TEACHER ANNE ARUNDEL COUNTY Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ပ WILLIAM T. REID MAY BEAMON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD JONES (SON) 6138 MAJORS LANE COLUMBIA, MARYLAND 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ C Removal from State emation 4 Donation 5 Other (Specify) MARYLAND NATIONAL 8-20-2009 LAUREL, MARYLAND 21. Signature of Fu HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Due to (or as a consequence of): **Physician** disease condition resulting in death) CERTIFICATION APPROVED BY MEDICAL EXAMINER /Medical Examiner ANEMLA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine DEMENTIA physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 25. Was case referred to medical examiner? 1 □Yes 2 Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1X Yes 2 No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 21 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29b. Signatur 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year) AUG 1 2009

HIAM

Registrar's Signat

09-06243 Hector Rodriguez

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certifier  O.C.M.E.  August 11, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		. B. the de shed f	<sup>2</sup> hy		9 GIRIOWII	th but not re	esulting in the t	inderlying caus	e given in Pa	art I.	23e. Did to	obacco use c	ontribute to	the cause of death?
29b. Signature and title of certifier  O.C.M.E.  August 11, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		that the detac												
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29b. Signature and title of certifier  O.C.M.E.  August 11, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		ord aw rec as bee 2 shou	ple								autop	sy	prior to d	
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29b. Signature and title of certifier  O.C.M.E.  August 11, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Dipital ours a filled filled	Cert	4 Homicide	(5,55)									
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29b. Signature and title of certifier  O.C.M.E.  August 11, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature														
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Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				my m	, wie			0.	O.IVI.⊏.			August		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature								at Baltimor	o MD 244	201				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, 2009 Month AUGUST Day **Physician** Evelyn Lorraine Stadelman 6:54F M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 26, 1918 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) **Funeral** Days Maryland 215-07-3438 1 □ M **χ**[χ]F 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at MD Baltimore 1∏Yes 2∏No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 USA 5036 Wright Avenue Funeral 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2√∑Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify: white <u>ک</u> Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Box Factory Inspector permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Elizabeth Rites Robert Shaw ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5036 Wright Avenue-Baltimore, Maryland 21205 Patricia Carey-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel and Cremation-Belair 20c. Location - City or Town, State 20a. Method of Disposition Aug. 16, 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road Evans Funeral Chapel and Cremation Services Parkville, Maryland 21234 41 ondiae Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical attending p IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 : autopsy perform this certificate 2 No 1 ☐ Yes 2 No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 15 W. 32. Registrar's Signature State park Registrar

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11cm 5 per fh g896 10-20-09 vt State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		, , , , , , , , , , , , , , , , , , , ,	Ce	ertificat	e of i	Death			Reg. N	lo.			
	Physicia	20	1. Decedent's Name (First, Middle							Date of Death Month Day Year 3 Time of Death						
	/Medic		Thelma Mae Souders					Aug					2009	6:50 P M		
	Examin	er	4a. Facility Name (If not institution	-					Location				c. County of Death			
			Heartland Assis	last birthday		erna r 1 Year	Park If Under		8. Date of B		nne Arund	del  pplace (State or Foreign				
	Funeral Director		<del>215</del> -18-0275	Yrs.	Months Days Hours Min. (Month, Day, Year) Country)						intrv)					
Z15-0036 this 72 hours after death with the Maryland	pu. ×		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside										10d. Inside City Limits			
	laryla shov	ō	Maryland Anne A	rundel		sadena								1 ☐ Yes 2 ☒ No		
	the N	rect	10e. Street and Number					Code				10g. C	10g. Citizen of What Country?			
	h with	Funeral Director	109 Altoona Ave				21122						ted State	-		
	death	iner	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13	. Was Dece	dent of H	lispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	lo-	14. Race - American Indian, Black, White, etc.			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Andreal Event her must be notified at once.	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 □ Divorced Year or Dates:				1 □Yes		Specify.		r noarr, oto.,		Specify: White			
2	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)				edent's Usu e kind of wo	rk done d	durina mos	st of worki	ing	16b.	Kind of Business/Ir	ndustry		
2	vithin sne. than '	Idm	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	<i>ро мот и</i> phone		•			Co	mmunicati	ione		
N	filed v Hygie <b>ther 1</b>		17. Father's Name (First, Middle,	Last)		1010	phone	Open		-	(First, Middl			.0115		
and	d be ental ked o	To Be	Frank J. Brown	,							. Beatt		,			
ary	shou and M s mar umat	-	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mai	ling Address	S (Street					y or Town, State, Zi	ip Code)		
, ga	and 2 salth a n 27 is		Terry L. Shephe	rd / Neph	ew	1191	2 Wood	lburı	n Dr.	, Ha	gerstov	m,	Maryland	21742		
baltimore	jes 1 t of He if Item or oth	l î	20a. Method of Disposition	3 ☐ Removal from S	20b. F	Place of Disp cemetery, cre	osition (Na ematory or o	me of other plac	e) A		t 19,	20c.	Location - City or T	own, State		
	t. Pag tment tant: ijury o		4 Deponation 5 Other (Specify) Glen Haven Mem. Pk. 2009 Glen Burnie Maryl													
ga	permit Depar Impor any ir once.		21. Signature of Funeral Service	Licemee		K 4	irkley 21 Cra	nd Addre Z-Ruc ain I	ss of Facili Idick Iwy.,	Fune S.E.	eral Ho	ome, i Bu	P.A. rnie, MD	21061		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										Approximate			
F	hysician	ři 1	Immediate Cause (Final										Onset and Death			
M	/Medical		resulting in death)	Cl.	or as a conseq		Gen.	100	111	1			(	Je ac		
	Examiner	_	Sequentially list conditions,  Due to (or as a consequence of):													
0 .	ted Isit	nine	Sequentially list conditions, if any leading to manage cause. Enter Underlying Cause (Disease or injury that is listed examples)	uence off:	ice of):						- 1					
19	execu n and al-trar	Examiner	that initiated events resulting in death) Last	uence of):												
00/00	icate be executed physician and the burial-transit															
0	ng phy as th	Medical	IT TENAL C			_										
. BOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown									23d. Date of delivery  Month Day Year				
Τ,	that t		Pract II. Other significant continuous continuous to dearn out not resulting in the underlying cause given in Part I.								23e. Did	23e. Did tobacco use contribute to the cause of death?				
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ב ב	The It	шо									aut per 1 □Yes	opsy formed? 2	death?	ompletion of cause of 2   No		
VII all	ertifica ctor, p	Be C	© 25. Was case referred to predical 26. Place of Death (Check only one)									Assis ted				
5	this or	၉	1 ☐ Yes 2 ☑ No		npatient 2				4 🗀 🛚 🔻				idence 6 Mother (Specify) Living			
	After After funera	ion:	27. Mann of Death 1 Latural 5 ☐ Pendin	9	of Injury h, Day, Year)	28b. Time Injury	of 2	28c. Injur Worl			28d. Describe	how inj	jury occurred			
SION	death death ctor: y the	ficat	2 Accident investig	not be	of Injury - At ho	ome, farm, s			Yes 2□		28f. Location	on (Street and Number or Rural Route Number,				
<u> </u>	al or A s after I Dire	Certification:	4 ☐ Homicide determ	buildir	ng, etc. (Specia	(y)		City or Town, State)					a riodic romaci,			
Losnita	or the hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical (	29a. Certifier (Check only one)  1 Certifyin 2 Medical	g Physician: To the Examiner: On the ba and mann	asis of examina	wledge, dea	ath occurred investigation	at the tinn, in my c	me, date a opinion, de	nd place, ath occur	and due to th red at the time	e cause e, date a	e(s) and manner as and place, and due	stated. to the cause(s)		
	vithii To th	Me	29b. Signature and title of certifier	11	a	N	11) 29	c. Licens	e number	125			Date signed (Month			
	10		30. Name and address of person	who completed cause	e of death (Iter			100	カで	Hi	he de	1.4	lover	2009 Ue 218		
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa		0	- Wi	, ,	/	7		F. 3V1			
	Registr	ar	AUG 18 2009	Denvin	p. 19	barka				V						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Doris Virginia Spindler /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Bathmore or 1 Year If Under 24 Hrs. St. Agnes Hospital Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Days Hours 218-36-2279 Director 90 June 24, 1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Sulphur Spring Road 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Completed by Specify: White Widowed 4 □ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) : Pages 1 and 2 should be filed wi tment of Health and Mental Hygier tant: If Item 27 is marked other th jury or other traumatic event, Thy 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William Walsh 2 Jenny Bush 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Spindler - Son 2107 Stonewall Rd., Catonville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Bunal 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 6 □ Other (Specify) oudon Park Cemetery 8-17-2009 Baltimore, MD 22. Name and Address of Facilit Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Lice 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, The cardiovarule of seaso Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): use as the burialphysician by Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.O. signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 20 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c License number DS2476 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chasce Care belf with July Wordland Chasce Care belf with July 18 31. Date filed (Month, Day, Year State 18 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Please T	ype or Print					•		•		
	State of Maryland / Department of Health and Mental Hygiene										00000	
		Registrar  1. Decedent's Name (First, Middle, Last)			Certifica	ate of l	Death 	2. Date of De	Reg. No.	2003	26323	
Physi	cian	JOHN KENN	ETH 7	ATE	-	5R.		Month August	Day		3. Time of Death 06:37 P M	
/Med		4a. Facility Name (If not institution, give s		TTIC		,	Location of Death		4c.	County of Dea		
Exam	liner		Balhmore				re city			,		
Funera Directo		5. Social Security Number 6. Sex 212-90-9971		(In yrs. last birtho	Month	der 1 Year Is Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	a <i>y, Year</i> )	Co	thplace (State or Foreign ountry)	
and w		Usual Residence of Decedent  10a. State 10b. County						10d. Inside City Limits				
/laryla f sho led at	ō		ar Location	2017	OF				1 ⊈Yes 2 □ No			
the N 28a- notif	Director	10e. Street and Number		ی:		Zip Code			10g. Citi	zen of What Co	puntry?	
a with		2609 Shirley Avenue					215		13	.S.F	١.	
death ms 2 rmus	Funeral		2. Was Decedent Ev		13. Was Dec		ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	D-	14. Race - Ame		
or ite		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼No			pecity Cuba 2 <b>⊠</b> No	an, Mexican, Puerto  Specify:	o Rican, etc.)		Black, White		
ours ours	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I Li Tes	2140	эреспу.			Specify: 13	CACK	
7.72 hours after death with the Marylan 7.72 hours after death with the Marylan "natural", or items 23a or 28a-f show dical Examiner must be notified at	ete	15. Decedent's Educ (Specify only highest grade	ation completed)	1 (0	ecedent's Us Give kind of v	vork done o	durina most of work	king	16b. Ki	nd of Business	Industry	
within sne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  DISABLED								NIF		
be filed within 72 ho ital Hygiene. dother than "natur event, In Medical		17. Father's Name (First, Middle, Last)				3F101	18. Mother's Nam	ne (First, Middle	l , Maiden	·	r	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To Be	JOHN KENN	JETH	TAT	E		IRA			m	9CK	
	-	19a. Informant's Name/Relationship (Typ		19b. N	failing Addre	ess (Street	and Number or Ru	ral Route Numb	er, City o			
12 mg s		MATONIA TATE	(SISTER	54	124	LYN	VIEW	AVE.,	BAL	TIMORE	E,MD 21215	
S = S		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Re	amoval from State	20b. Place of D cemetery,	isposition (N crematory o	lame of r other plac	re)	Date		cation - City or		
nit. Pages artment of ortant: If ite		4 Donation 5 Other (Specify)		MT. ZIO							E, MARYLAND	
permit. Page Department of Important: If any Injury or	JICE:	21. Signature of Euneral Service License	1/,	11.	22. Name	and Addres	ss of Facility  BRO	ww	R.	TUNER	AL HOME	
	_	23a. Part 1. Enter the disease, or complic	V. Will	clamo	2140	N.F.	ULTON	AVE.	BAL	TIMORE	Approximate	
		shock, or heart failure. List only one	e cause on each line.			lode of dylin	ig, such as cardiac	or respiratory a	arrest,		Interval Between Onset and Death	
Physiciar /Medica		disease or condition resulting in death)	a. Respirator failure 5 hours  Due to (or as a consequence of):									
Examine		Sickle all disease										
	Je l	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to for all pil									
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The law requires that the death certificate be at the has been signed by the attending physician age 2 should be detached for use as the burial	hysician/Medical	d.										
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s that gned k	by PI	Part II. Other significant conditions conf	ributing to death but	not resulting in th	ne underlying	g cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?	
w requires been sign should be	leted b	1 ☐ Yes 2 ☑ No 3 ☐ Pr									robably 4 🗆 Unknown	
law re as be 2 shc	plet							24a. Was		24b. Were at	utopsy findings available	
	Compl							auto perfo 1 □Yes	ormed?	death?	completion of cause of	
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Physician: r this certific ral director,	ပု	1 ☐ Yes 2.☑No		2 ER/Outp			4 Li Nursing H				ecify)	
ling F	jo n:	27. Manner of Death 1.☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, )	<i>Year)</i> 28b. Tin Inju	ıry	28c. Injury Work		28d. Describe	how injury	y occurred		
Attending r death. ector: After by the funer	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury, At home, farm, street, factory, office 28f. Loc							28f. Location (Street and Number or Rural Route Number,			
after after Dire	Certification:								wn, State,		arai rioute rvamber,	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1- Certifying Phys (Check only one)	ician: To the best of er: On the basis of er and manner state	xamination and/	death occurre or investigation	ed at the tir on, in my o	ne, date and place pinion, death occu	, and due to the	e cause(s) , date and	and manner a place, and due	s stated. e to the cause(s)	
To th within To the	Me	29b. Signature and title of certifier			2	29c. License	e number		29d. Dat	e signed (Mont	h, Day, Year)	
		> Cus Mo	)			Ri	RES-000 A			ust 10,	2009	
<b>7</b> 7		30. Name and address of person who cor			pe, Print)			1	, 1 1			
		Cecilia H. Yshii - Ta				Sinai	Hospital	otk	ath	mort		
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 1 8 2009	A Land Strans	s Signature	arkad							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene per dvr Certificate of Death Reg. No. 100 Per dvr 26324 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2000 3:55 PMEmmie Tucker August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 24 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 048-22-8693 Months Days Hours Min. RIDGEVIJIE, 88 Director 920 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, inc. Medical Experience must be notified at Director 1 ✓Yes 2 No DORCHESTER KidgeVIIIE 10e. Street and Number 307 Highway 78 10f. Zip Code 10g. Citizen of What Country? 4. I.A 21703 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Specify: BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' YESICAL Elementary/Secondary (0-12) College (1-4or 5+) MENTAL RETRADATION SAC FIELD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALEXANDERSON RICHARDSON GREEN KATIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOPIFFRONIA Swallowtail Dr. Frederich Wid 21703 /uchen 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1⊿ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Bethel Ch. AWE Com Aug 8, 2009 Ridger le 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CARY L. ROLLINS FUN 10ME banx. 110 WEST SOUTH ST FREDERICK MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) syostole **Physician** seconds /Medical Due to (or as a consequence Examiner imbalances Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760. physician Physician/Medical bstruction. the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ helongiocaranoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown netastan page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 100 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Sother (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 2. State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Yea

back

Thomas Johnson Drive FRONDRICK MARYLAND 21701

29d. Date signed (Month, Day, Year)

2009

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

46 B

MD

32. Registrar's Signature

09-06313 Sheldon Taft

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

sheldon Laπ		State of Maryland / Department of Health and -For State Certificate of Death	0000
Physicia		1. Decedent's Name (First, Middle,Last)	Reg. No.  2. Date of Death  Month  Day  Year  1404 beath
Medical Examir		Sheldon Taft	August 12, 2009 1401 nrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L Northwest Hospital Randallstow	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		312-72-7736 1XM 2 F 49 Yrs. Months Days	Hours Min. 10/09/1959 Foreign Country) Maryland
ny	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
thow a		Maryland Baltimore Windsor	//:// 1 _ Yes 2 ▼ No
Aaryland 28a-f sho 1 at once	Director	Maryland Baltimore Windsor  10e. Street and Number 10f. Zip Code  7532 State Drive 21.	10g. Citizen of What Country?
with the Maryland us 23a or 28a-f sho be notified at once			
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban,	panic Origin? ( Specify Yes or No- Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
ifter de		1 X Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No	specify: Specify: Black
hours a	ed b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation during most of working life.	
36 hin 72 e. than "	Completed by	Elementary/Secondary (0-12)  College (1-4 or 5+)  Environmental El	ogineer Supervisor Maryland Club
D 21215-0036 should be filed within 72 hours and Mental Hygiene. 7 is marked other than "naturnatic event, the Medical Exam	팅	17. Father's Name (First, Middle, Last)	8. Mother's Name (First, Middle, Malden Surname)
121 d be fill lental I arked	a		BARBARA White
MD 21215-0036 42 should be filed within 72 th and Mental Hygiene. n 27 is marked other than " numatic event, the Medical.	]٤		and Number or Rural Route Number, City or Town, State, Zip Code)  Court, Windsor Mill, MD 21244
- 2 - 5 - 5	1	20a. Method of Disposition 20b. Place of Disposition (Name of cerr	
Pages nent of ant: It		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	rey 08/19/2009 langewere, Maryland
Baltimore, permit Pages   ar Department of Hee Important: If itee	Ī	21. Signature of Funeral Service License 22. Name and Address	
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying,	such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical vaminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic cardiovascu	lar disease Between Onset and Death
Vaimmer		or condition resulting in death)  Due to (or as a consequence of):	
	Jer.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
kecuted n and transit	<u>~</u>	d	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the the theorem of the thin secution or the funeral Director: After this certificate has been signed by the attending physician and oppletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	X UNPENDED AMENDED 23a,27,permE, g897 11/3	
1876 rtificate ing phy as the l	W/ug	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d. Date of delivery  Ectopic pregnancy Month Day Year
Box 687 death certific	Sicie	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	
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ital Re sician: Th s certifical	Be	examiner? Hospital: 1 Innation 2 P EB/Outpatient 3 DOA	of Death (Check only one)  Other; Nursing Home 5 Residence 6 Other:
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Division spital or Attendin hours after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office by	uilding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Tospita f hours uneral		29a. Certifier 1 Contifuing Physician: To the best of my knowledge, death occurred at the time, day	te and place, and due to the cause(s) and manner as stated.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at the time, date and place, and due to the cause(s)
F » F »	<b>ĕ</b>	29b. Signature and title of certifier 29c. License	
		Theodon W. King Thyme. D. O.C.M	M.E. 0CME August 13, 2009
		30. Name and address of person who completed suse of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 21201
Sta		31. Date filed (Month. Day Year) 37. Registrar's Signature	
Registi	ar	AUG 18 2009 Jenus S. Jacks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19b, per FH 8894 8/18/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:35 PM /Medical 4a. Facility Name not institution, give street and number **Examiner** Battimor Social Security Number 6 Sex n yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. M 2□ F Director 28 27,1928 81 N.C Mar. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evan, and India and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** XI □Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1114 E. Belvedere Ave. 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify. ģ Specify: black 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Bethlehem Steel Truck driver 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Raymond H. Toney, Sr. Elsie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37042 375 S. Lancaster Rd. Apt. 67, Calarsville, TN 19a. Informant's Name/Relationship (Type. Print) Diana Toney (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. Aug. 21, 2009 Balto, Md. Signature of Funeral Service Licensee 22. Name and Address of Eacility Calvin B. Scruggs Funeral Home E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ntra cromal **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> cate has been sig 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. P21715 ted cause of death (Item 23a) (Type, Print) Loch Roven Blvd., Baltimore, MD 21234 5601 31. Date filed (Month, Day, Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND TITEM#8perFH, 6895,9/2709, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 6 Day Month **Physician** C. Wiggs 2009 Edith 10:00aM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Future Care 8. Date of Birti6/22/1931 9 Balto If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 💢 F 217-34-9048 MD 78 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified Completed by Funeral Director MD 1 Yes 2 No N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 123 W. 29th Street 21218 US 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 Specify Black 1 □Yes 2 No Specify 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th grade N/A other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Amanda Gibson Charles C. Green ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise Wilson-Daughter 3802 Byxbee Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-25-2009 Owings Mills, MD 4 ☐Donation 5 ☐ Other (Specify) Garrison Forest 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary antern /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last therosclosol Examiner Due to (or as a consequence of): ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatb? Completed by 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DARSHAM 1600 MOUN 32 Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 per Fh 9894 8/25/09 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>200</u>9 <u> Charlotte Shaw Wadsworth</u> August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours 2 (1/3/1/1924ear) Pennsylvania Director 84 Usual Residence of Decede marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Aberdeen Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1220 Perryman Road 21001 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 🔀 Married Completed by ☐ Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours IDepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Whipkey Gladys Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd J. Wadsworth (Spouse) 1220 Perryman Rd. Aberdeen, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Mem. Gdns. 8/19/09 Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home,
Maryland 21001-3 21. Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 Wadsworth IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform completed filled in by the funeral director, 25. Was case referred to medical harlotte Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 No မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dealt 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending Natural Accident 5 Pending 1 Yes Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Proclumer To the Log I my mount of a state of the cause (s) and control of the cause (s) and manner stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) lunas

State Registrar 81. Date filed (Month, Day, Year) AUG 18

32 Registrar's Sid

#### Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Bernice Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai HOSPITAL BALTIMORE of BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday) **Funeral** Bernice Marie Ward Days 1 □ M 2 💢 F 212-70-6608 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it would not be notified at once. Directo MD NA Baltimore 10e. Street and Number 6922 Reisterstown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 17 Vac 2 7 VNa þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Khown as Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs 17. Father's Name (First, Middle, Last) Frederick Douglas Sr. 19a. Informant's Name/Relationship (Type. Print) Anthony Ward-Husband 20b. P 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Κi 21. Sign tur of Funeral Service Licenses 23a. Parti . Enter the disease, or complications that caused the shock, or heart dilure. List only one cause on each line. Immediate Cause (Final Physician DEPSIS disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CUTE Due to (or as a consequ Examine physician and the burial-trans Due to (or as a consequ Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: yes, outcome of pregnar ☐ Live birth 2☐ Fetal 23b. Was decedent pregnant in the past 12 months? 4 ☐ Pregnant at time of de 9 ☐ Unknown To the Hospital or Attending Physician: The law requires that the de within 24 hours. Her dea.h. To the Funeral Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached formulated. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resu Completed by PULMONARY 25. Was case referred to medical examiner? Be 2 No Hospital: 1 ☐ Yes 1 Inpatient ည 2 🗆 E 27. Manner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 2 Accident

30. Name and address of person who completed cause death (Item

3 🗌 Suicide

29a. Certifier (Check only

cal

4 🗌 Homicide

31. Date filed (Month, Da

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disease, or complice	cations that daused the	e death. Do n	4300 Wak				Md 21215 Approximate
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5 ☐ Pending investigation	(Month, Day, Y	<i>ear)</i> In	jury   Wo	orkí? ⊒Yes 2. ⊒No		, , , , , , , , , , , , , , , , , , , ,	
6 ☐ Could not be determined	28e. Place of Injury	- At home, far	m, street, factory, office		28f. Location (	Street and Num	ber or Rural Route Number,
determined	building, etc. (	Specify)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)	
Certifying Phys	ician: To the best of n	ny knowledge.	death occurred at the	time, date and pla	ce, and due to the	cause(s) and r	nanner as stated.
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Day, Year)	32. Registrar's	Signature	11	PITAL O.	T DALT	MORE.	
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2. Date of Death

August

2218

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

Y Yes 2 □ No

2009

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10g. Citizen of What Country?

U.S.A.

14. Race - American Indian,

Black, White, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Ward

Hours

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Registrar DHMH 17 Rev 1/2001

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-48-	/Medic		Stanley John  4a. Facility Name (If not institution, give s			4b City Town or	Location of Death	August	12, 2009	
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			581 Eason Drive 5. Social Security Number 6. Sex	7 Age (6	n yrs. last birthday)	Seve	rn If Under 24 Hrs.	8. Date of Bin		Arundel
	Funeral Director		11X	M 2□F	- Vrc	Months Days	Hours Min.	Nov 1		9. Birthplace (State or Foreign Country) New York
			Usual Residence of Decedent	59	9	1		NOV 1	1949	New TOLK
	/land		10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	ander		10f. Zip Code			10g. Citizen of WI	hat Country?
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Madical Examinational be notified at	Completed	15. Decedent's Educ (Specify only highest grade			dent's Usual Occupa		rking	16b. Kind of Bus	iness/Industry
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<u>a</u>	should to	10	Stanley Geor	ge Wziente	ek		Bertha	Bial	ota	
Maryland			19a. Informant's Name/Relationship (Type	pe, Print)	19b. Maili	ng Address (Street a	and Number or Ru	iral Route Numbe	er, City or Town, S	State, Zip Code)
Σ,	and salth		Kathi Lynn Wzientel	k/wife	581	Eason Dri	ve Seve	rn, Mar	y1and 21	144
Ze	of He		20a. Method of Disposition		20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	se)	Date	20c. Location - C	City or Town, State
Ĕ	Page nnt: In		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)		West Arun	del Crema	tory 8/1	4/2009	Odenton.	, Maryland
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medicai	one)	ner: On the basis of ex and manner stated	difficultion and/or in	vestigation, in my of	pinion, death occu	mad at the time,	uate and place, at	in doe to the canse(s)
	To t With To t	Σ	29b. Signature and title of certifier	171	7	29c. License	e number		29d. Date signed	(Month, Day, Year)
•			1 Jans	16		D315	51		August	13, 2009
	Intl		30. Name and address of person who co	impleted cause of deat	h (Item 23a) (Type,	Print)				
_	14.		Russell R. DeLuca			1 Drive	Glen Bur	nie, Mar	ryland 21	.061
1	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	- 17 A	10	-			
25	Registr	ar	AUG 18 200	9 Ocheva	1. D.	arkad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2633 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1955 AM yatt HOUST 4a, Facility Name (If not institution, give street and number) 4c. County of Death KALTIMORE NASHINGTON NOURNIE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🗓 F Hours 219-13-1210 23 Maryland 12-03-1985 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Anne Arundel MD Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 649 Chapel Gate Drive 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 X Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Newspaper Deliver Person Maryland Gazette 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gary E. Wyatt Deborah Lynn Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Harvey / Mother 7959 Telegraph Road Lot 65 Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 08-11-2009 Elkridge, Maryland re of Funeral Service Lice <sup>12</sup> Name and Address of Facility Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland 21113 23a. Rart 1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmenale Cor day Due to (or as a consequence of): and hemor- hage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 3d. Date of delivery Month Day Year vn

**Physician** /Medical **Examiner** Examiner Hospital or Attending Physician: The law requires that the death certificate be

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "medical Exant in action to other traumatic event, the "medical Exant in a to rectified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran page 2 s filled in by the funeral

Division of Vital Records, P.O. Box 68760, T

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Onknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	. 2:
Part II. Other significant condition:	s contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco us
			24a. Was an autopsy performed?

dical	•	d	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Onknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
þ	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknow
Completed			24a. Was an autopsy performed?  Yes 2 \[ \] No  24b. Were autopsy findings availal prior to completion of cause of death?  1 Yes 2 \[ \] No
Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
2	1 Tes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	on (Month, Day, Year) Injury Work?  M 1 □ Yes 2 □ No	3d. Describe how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street and Number or Rural Route Number, City or Town, State)
dical (	29a. Certifier Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)

29c. License number

D0062123

29d. Date signed (Month, Day, Year)

5 2009

completely within 2

> State Registrar

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) DANICA NOVACIC

Glen Burnie, MD 21061 Hospital 32. Registrar's Signature

31. Date filed (Month, Day, Year)

24 hours after death Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Pay 20ď **Physician** August 1:27 BLACK ДM ELIZABETH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Rockville Nursing Home 8. Date of Birth (Month, Day, Year) Feb.15,1919 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Michigan 1 □ M 2 😾 F 90 374-18-4648 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Nedical Eventrics must be notified at 1 ☐ Yes 2 No Director MD Gaithersburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 72 hours after death with United States 20879 9706 Winery Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify. þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be it and 2 should be fill Health and Mental H tem 27 Is marked otl Faith Blakeslee Clark Strohmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 Is. any injury or other traus 20525 Aspenwood Lane Montgomery Village Bruce D. Black (Son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) August 03 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service icensee urtis 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) eaus **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician requires that the death certificate be Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Month Year Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No P.O. ned by the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) funeral ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated To the within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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State Registrar

Shama Mittal M.D. 31. Date filed (Month, Day, Year) AUG 04



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0061382

August 3, 2009

Rockville, MD 20850

Please Type or Print in Black indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Elisa Martinez Belt Elisa Martinez de Belt , 2009 August 2 10:55 A 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda 5224 Elliott Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days 1 □ M 2 🖾 F Yrs. 98 07/23/1911 Cuba None Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County YYes 2 □ No Bethesda Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20816 Cuba 5224 Elliott Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐ No Specify: Cuban Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jose Agustin Martinez Elisa Silverio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guillermo A. Belt / Son 1808 Melbourne Dr. McLean, VA 22101

e of Disposition (Name of Disposition (Name of Disposition (Name of Disposition)) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State 08/04/2009 National Crematory |Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. WN Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Lymphoid Leukemia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 1 \( \text{Yes} \) 2\( \text{X} \) No 26. Place of Death (Check only one) Other: 4 Nursing Home A Residence 6 Other (Specify) Hospital 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

68760. Box Ö σ. of Vital Records. Division **Physician** 

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**Examiner** 

**Funeral** 

Director

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**Physician** 

/Medical

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transit and physician Physician/Medical the attending p for use as t IF FEMALE: 23b. Was decedent pregnant the ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Š Seizure Disorder Completed cate has I page 2 s Mild Dementia certificate Physician: 25. Was case referred to medical Be ၉ To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di this 27. Manner of Death Certification: 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical and manner stated. 29d. Date signed (Month, Day, Year) and title of dertifier 29c. License number 29b. Signature

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31. Date filed (Month, Day, Year) State

AUG 04 2009

Michael Solomon MD 5530 Wisconsin Ave. #930 Chevy Chase, MD 20815 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0060167

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Registrar

by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and by the attending physician and	July Residence of Decedent    Oa. State	Cuu Te Ban  we street and number)  Sex  1	yrs. last birthday) 77 Yrs.  City, Town or Louin U.S.  16a. Dece (Give life.)  19b. Malli 981  Ob. Place of Discovered Pry. cree Gate of	If Under 1 Year Months Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  Days  D	ilver Spri  If Under 24 Hr.  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State	30. Name and address of person wh Huyamh Ton, M.D.			10 #210 m-	koma Parti	Marrian	d 20912	)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUK 31 2004 ames rnest /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital Baltimore City Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9/23/1948 **Funeral** Months 1 XM 2 F 60 MD 218-48-5367 Director Usual Residence of Decedent 10d Inside City Limits 10h County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2X No Director DE Sussex Millsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 22698 Bethel Rd. 19966 USA items 23a Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify: white 'natural", or ģ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education filed within 72 (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) than Grocery / Retail 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. Be Albert Timothy Baker Ella Gertrude Parker ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Irene Baker / wife 22698 Bethel Rd., Millsboro, DE 19966 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pittsville Cemetery 8/4/2009 Pittsville, MD Service Licensee 21. Signature of Fun eral 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enjet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or nearly allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final In + va - ando minal Due to or as a consequence of): **Physician** Hemorrhage disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 1 1 🗌 Yes l or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3 DOA 6 Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: after death. 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D 1 Stretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

(check only

29b. Signature and title of certifier

Helqeson Asniey 31. Date filed (Month, Day, Year) AUG 0 5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

29c. License number

Res - 000

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

completely

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			,	Ce	rtificate of	Death	,	Reg. No.	009	25336
	Dhyaiai	an.	1. Decedent's Name (First, M	liddle, La	st)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Leonard	Sar	uel Barre	tt				July	30	2009	0704A M
Tank.	Examin		4a. Facility Name (If not insti	ution, giv	e street and number)			4b. City, Town, o	r Location of Death	1		ounty of Death	
mell.			5401 Coastal		way #302	- //m	la at hinth day	Ocean C		8. Date of Bir		cester	lace (State or Foreign
	Funeral Director		5. Social Security Number 216-07-8233		M 2□F	93	last birthday Yrs.	Months Days	Hours Min.	9/10/1	ıy, Year)	MD Coun	try)
	and and		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or Lo	ocation				10	0d. Inside City Limits
	Maryl f sho	ţō	MD Wor	cest	er	000	ean Ci	tv					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number					10f. Zip Code			10g. Citize	en of What Coun	try?
	23a o	a	5401 Coastal	Hio	hway #302			21842			USA		
136	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Evanthet must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2□ 3 ☑ Widowed 4 □ Divo	Married	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates;	Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No		pecify Yes or No o Rican, etc.)		4. Race - Americ Black, White, e	etc.
ž	2 hou	ted			ducation ade completed)		16a. Dece	dent's Usual Occup	pation	, .	16b. Kind	d of Business/Inc	dustry
1215-0036	thin 7. e. an "n	Completed	(Specify only h		ade completed) College (1-4or t	5+)	(Give	kind of work done DO NOT use retire	during most of wor d)	king			
	filed within Hygiene. other than "	S	8				Dri	ver					Call Truck
$\subseteq$	be de de de	Be	17. Father's Name (First, Mic						18. Mother's Nar			urname)	
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_ Z	d 2 sl Ith an 17 is r traur		19a. Informant's Name/Rela Mary Lynne Bo					ng Address (Street Coastal					
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Ö E	permit. Pages Department of Important; If its any Injury or o		1 XBurial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth					matory or other pla /alley Cei		2009	Timon	ium, MD	
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П			23a. Part 1/Enter the diseas shock, or heart failure.	e, or com	nplications that caused	d the deatline.							Approximate Interval Between Onset and Death
<i>J</i>	certificate be executed /Medical Examiner upon properties as the burial-transit	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	{	a. Due to (or as b. Due to (or as c. Due to (or as d.	a coliseų	uerice of).	C 9115	DIOVASC	041	ν/ >(	JIS E	
ñ.	eath certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 🗌 Feta	death 3	□ Ectopic pregnand □ Other (specify) _	су		23	3d. Date of delive	ery Day Year
S, T	w requires that the d been signed by the should be detached	by	Part II. Other significant con	iditions	contributing to death b	out not res	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did 1		e contribute to th	ne cause of death?
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ě	e a las	Comple								24a. Was auto perfo		prior to col death?	psy findings available mpletion of cause of
_	10 14	မ Co	25. Was case referred to me	dical	1			_	00 81 - 48	1 □ Yes	2 <b>W</b> 0	1 ☐ Yes	2 🖟 NO
5	Physician: this certific ral director, I	o Be	examiner?	ulcai	Hospital:	ent 2 🗆	EB/Outpatie	nt 3 DOA Oti	26. Place of Dea			Other (Specif	
0	ding Physician: n. After this certific funeral director,	I ⊢ I	27. Manner of Death		28a. Date of Inju	ury	28b. Time of			28d. Describe			<i>y)</i>
VISION	ath. rr. After ne funera	atio	Z LI Addidont	vestigatio		iy, rear)	Injury		Yes 2□No				
NIVIS	al or Atte s after de I Directo id in by th	Certification:		ould not be etermined	28e. Place of In building, et	jury - At ho tc. <i>(Specif</i>	ome, farm, st	reet, factory, office		28f. Location ( City or To		Number or Rura	l Route Number,
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After to completely filled in by the funera	edical (			hysician: To the best miner: On the basis of and manner st	of examina							
	To th withir To th comp	Me	29b. Signature and title of ce	rtifier				29c. Licen:	se number		29d. Date	signed (Month,	Day, Year)
			VUlan	nu	LIVI	1	40	260	15/5		8	12/09	
			30. Name and address of pe			death (Iten	n 23a) (Type	Print)				/-/	21804
Dr	15+1		M. THINU	11/0	MYMPIN	rar's Signa	5/4	B EA.	STEKN	SHOR	E DI	R SALL	CRUCYMD

AUG 0 5 2009 Server S. Janes

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G894 8/28/09 JH Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health and Mental Hygiene, and a state of Maryland / Department of Health All Hygiene, and a state of Maryland / Department of Health All Hygiene, and a state of Maryland / Department of Health All Hygiene, and a state of Maryland / Department of Health All Hygiene, and a state of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 8 **Physician** 0100 M Brad Shau 7009 sertha W. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Combridge MUD Mallard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Sacral Sacrity diviniba **Funeral** Hours Days 1□ M 2 F 86 1922 Oct. 6, Marvland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f show traumatic event, the Medical Examiner must be notified at Seaford Dorchester 1 Tyes 20 XNo ML Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19973 United States 5528 Galestown Newhart Road items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō White 1 ☐ Yes 2 👿 No Specify: þ 3X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Il Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 (Grad.) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Wheatley Mary Wallace 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trac 5524 Galestown Newhart Rd., Seaford, DE 19973 Howard J. Bradshaw/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 Cremation 3 Removal from State 08/10/09 Hurlock, Maryland Eastern Sh. Veterans 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final week **Physician** renal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner congestive month Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician a O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the aid be detached for 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by pressure hydrocephalus 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy After this certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation within 24 hours after community the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 8/5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge MD ohnson Bramble 100 gistrar's Signature 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:04 a.M Bloodsworth 2009 Morris Wissman August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dorchester 1309 Race Street Cambridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1⊠M 2□F 218-20-8237 82 5. 1926 Maryland Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Dorchester Cambridge 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 1309 Race Street 21613 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. l ∐Yes 2⊠ No f Yes, Give 1 Never Married 2X Married 1∐Yes 2ŽiNo Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mechanic automotive 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marcie W. Bloodsworth Ruby Powley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Malinda Bloodsworth wife 1309 Race St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 8/4/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Thomas Funeral Home P.A. Lk Tlerra 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed burial-trar physician the attending phase as the ed by the a detached f signed to has page 2 certificate Physician: funeral director,

this

After or Attending

within 24 hours after death

To the Funeral Director:
completely filled in by the

death.

To the Hospital

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be 2 Medical Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗌 Unknown 25. Was case referred to medical examiner?

1 ☐ Yes 2 KNo

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X** No 1 Yes

2009

26. Place of Death (Check only one) 2 ER/Outpatient 3□ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day Year)

Malke 408 Byen Mark 31. Date filed (Month, Day, Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State Registrar

O

**AUG 04** 

5 Pending

investigation

6 Could not be determined

		•	For State Registrar	State of Mar	-	epartment of F Certificate of		F	Reg. No.2 () ()	9 26339
ľ	Physicia /Medic		Decedent's Name (First, Middle     BRENDA	e, Last) LAFAYE COOPE	R			2. Date of Dea	Day Ye	3. Time of Death 11:30 A M
-	Examin		4a. Facility Name (If not institution Shady Grove Ad		tal		Location of Deat	h	4c. County of I	
	Funeral Director		5. Social Security Number 579–02–7242	6. Sex 7. Age (	In yrs. last birth	Months Days	If Under 24 Hrs Hours Min.		, Year) , 1964 M	Birthplace (State or Foreign Country) aryland
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Monto	omery	Oc. City, Town C	or Location Saithersburg	<u> </u>			10d. Inside City Limits 1 ☐Yes 2 ☑ No
	h with the l	al Director	10e. Street and Number 9359 Merust I			10f. Zip Code	0879		10g. Citizen of Wha	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Midfall Even in a mult be natified at once.	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Black, V	American Indian, Vhite, etc. Black
Baltimore, Maryland 21215-0036	vithin 72 ho ne. <b>han "natur</b> Medicul	Completed	15. Deceden (Specity only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or 5+)		Decedent's Usual Occup Give kind of work done life. DO NOT use retired Housekeepe:	during most of wo i)	rking	16b. Kind of Busin	ess/Industry
land 2	id be filed w ental Hygie ked other t ic event, in	To Be Co	10th 17. Father's Name (First, Middle, Vernon R, C			110dbc1secpe.	18. Mother's Na	me (First, Middle, tie V. S	Maiden Surname)	
, Mary	and 2 shou salth and M 1 27 is mar er traumat	-	19a. Informant's Name/Relations Bernard Cooper			Mailing Address (Street 1807 Nathan:			-	ate, Zip Code) e , MB 20886
imore	Pages 1 at the ment of He tant; If item jury or oth		20a. Method of Disposition 1 □ □ □ □ Cremation 4 □ □ Donation 5 □ Other (S	pecify)	cemetery,	Disposition (Name of crematory or other place to compare the compare to compare the compare to compare the compare to compare the compare to compare the compare to compare the compare to compare the compare to compare the compare to compare the compare to compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the compare the co	8/:	Date 1/09	20c. Location - Cit	on, MD
Ball	permit Depart Import any in		21. Signature of Funeral Service	License		22. Name and Addre				•
	Physician /Medical	3 74	23a. Part 1. Enter the disease, or shock, or feart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each line.	ge Pulm	onary Fibr		c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury	M	-355	rtension				
68760, U	ificate be executed g physician and is the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of	rt Failure cory Failure				
		/Medical	IF FEMALE:	23c. If yes, outcome of		ory rarrary	<b>-</b>		23d. Date of	of delivery
.O. Box	that the death ned by the atter detached for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		Month	
rds, P.	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	þ	Part II. Other significant condition	ons contributing to death but	not resulting in t	he underlying cause giv	en in Part I.			ute to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law recate has be page 2 sho	Completed						24a. Was autop perfo 1 □Yes	psy pric priced? dea	re autopsy findings available or to completion of cause of uth? ]Yes 2 □No
f Vit	<b>hysician:</b> The la his certificate ha I director, page 2	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	11	2 🗆 ER/Outp	patient 3 DOA Oth	or:	ath (Check only o	ne) dence 6 ☐ Other	(Specify)
sion o	ding P h. After t funera	ertification: T	27. Manner of Death  1 Natural 5 □ Pendir  2 □ Accident investi	g 28a. Date of Injury (Month, Day, )	28b. Ti	me of 28c. Inju	yat k? Yes 2 □ No	28d. Describe h	now injury occurred	
<u>X</u>	는 를 들는	O	3 Suicide 6 Could determ	ined 28e. Place of injury building, etc.	(Specify)	n, street, factory, office		City or Tov	vn, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical		ng Physician: To the best of Examiner: On the basis of e and manner state	xamination and					
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	-		30. Name and address of person Vinu Gantı, M					MD 2087		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 04	32 Registrar's		barkes.				

	,	For Stete Registrar			State	of Ma	ryland /		ırtmen <i>tificat</i> i			ınd M	ental H	ygien Reg. N	- C U	09	263	40
		1. Decedent's Name	(First, Midd	le, Last)									2. Date of D		ay	Year	3. Time of	Death
Physici /Medic		Charles	E.		Clark								July			2009	3:25	P <sup>M</sup>
Examin		4a. Facility Name (#	not institutio	n, give s	treet and nu	umber)			4b. City,	Town, or	Location o	f Death		4	c. County	of Death		
		Glen Burr	nie He	alth	and :	Reha	ib. Cer	nter			ırnie			A	nne .	Arund		
Funeral		5. Social Security Nu	ımber	6. Sex	M 2□F	7. Age	(In yrs. last		If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of B (Month, L	irth Day, Yea	ır)	9. Birthp	lace (State o	r Foreign
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pu ,		Usual Residence of 10a. State	Decedent 10b. County				10c. City, T	own or Lo	oation							1	0d. Inside Cit	v Limits
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Ba-f	Director	MD	Anne	AL UI	idei				101 7	0.1.	WIII	Jiu		100 (	Titizan of	What Coun	tn/2	
with t	급	10e. Street and Num							10f. Zip		12			109. (		SA	шуг	
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rs aft	by F	3 XWidowed			If Yes, G	ive	942-4	6	I ☐ Yes	2 <b>⊠</b> No	Specify:				Specif	y: Wh	ite	
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otha otha	Be C	17. Father's Name (	First, Middle,	Last)							18. Mothe	r's Name	(First, Midd	le, Maid	en Sumai	ne)		
should be nd Mental marked c	To B	William A	Allan	Clar	k, Sr	•						]	Ruth S	ara	Blad	en		
should No man		19a. Informant's Na	me/Relation	ship (Ty)	oe, Print)		1	9b. Mailir	g Address	(Street a	and Numbe	r or Rura	l Route Num	ber, City	y or Town	, State, Zip	Code)	
1 and 2 Health a tem 27 le		Cheri McC	Collou	gh/S	stepda	ught	er	872	R Doi	ris I	Drive	, Arı	nold,	MD 2	21012			
S		20a. Method of Disp			1.6		20b. Place	e of Dispo	sition (Nar	ne of ther place	в)	C	ate	20c.	Location	- City or To	wn, State	
Pages nent of int: If its		1 ☐ Burial 2 ☐			emoval from	n State	Bayv	iew (	remat	cory	· .	7/31	/2009	Bal	timo	re, M	arylar	id
그 문문을		21. Signature of Fur	neral Service	License	50)			22	. Name ar	d Addres	s of Facilit	y Bea	all Fu	nera	al Ho	me		
Depa Impo		2	< +		2	-			6512	NW (	Crain	Hwy	., Bow	ie,	MD 2	0715		
		23a. Part1. Enter th shock, or hear	e disease, o	r compli	cations that	caused	the death. [	Do not ent	er the mod	e of dying	g, such as	cardiac c	r respiratory	arrest,			Approximate	ween
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/Medical		resulting in death)		•	Due to	(or as a	consequen	e of):	At L	WE	7							
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	ner	Sequentially list con if any, leading to import cause. Enter Under	mediate	,		(or as a	consequen	ce of):	-									
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The law requires that the death certific. The law requires that the death certific ite has been signed by the attending page 2 should be detached for use as:	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown			4∐Preg 9☐Unki		time of death	n 5L	Other (sp	ecify)								
that the de ed by the detached	Phy	Part II. Other signifi	cant condit	ione con	tributing to	death bu	it not resultin	og in the u	nderlying c	auca auve	on in Part I		23a Dic	1 tobacc	o use con	tribute to th	ne cause of c	eath?
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To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certifici completely filled in by the funeral director,	dical				ner: On the		examination						and due to the ed at the tim					.)
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09-05929 Yu Chen

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Yu Chen State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 29, 2009 0216 hrs Medical Examine 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Numb 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** UNK. Days Months Hours Director Country)TAIWAN 1 M 2 X F Yrs APR. 20,1934 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location any 10b. County 1 Yes 2 No or items 23a or 28a-f show must be notified at once. MD PRINCE GEORGES HYATTSVILLE within 72 hours after death with the Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2013 PEABODY ST. 20782 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces' White, etc. 1 Never Married 2 Married Yes 4 X Divorced f Yes, Give Yee 3 Widowed Yes 2 X No specify. Specify: ASIAN "natural" ⋛ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) ges I and 2 should be filed within 72 h to f Health and Mental Hygiene. I: If item 27 is marked other than "n. other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 2 KEY PUNCH OPERATOR HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK. UNK. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEIST/DAUGHTER 737 BOULEVARD AVE., SCHWENKSVILLE, PA. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, it. Pages l crematory or other place) 1 X Burial 2 Cremation 3 Removal from State GEORGE WASHINGTON CEM. 8-3-2009 Donation 5 Other Specify ADELPHI, MD. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a. Retroperitoneal Hemorrhage (Non-Traumatic) Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and Physician/Medical physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year 2 Fetal death Dav past 12 months? for use Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive Atherosclerotic Cardiovascular Disease Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed\* page ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26. Place of Death (Check only one) Be Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Other 2 No 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No Director: d in by the f Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined Funeral Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 O.C.M.E. July 29, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State record Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	•	epartment of H Certificate of L			giene Reg. No. ?	nna	2631.2
			negistrar     Decedent's Name	(First, Middle, La	st)				2. Date of De	ath	UUJ	3. Time of Death
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· Marie	Examin		4a. Facility Name (If	not institution, given	e street and number)		4b. City, Town, or	Location of Death		4c. Cc	ounty of Death	
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	Funeral Director		5. Social Security No. 223-31-3!	528	Sex 7. Ag	e (In yrs. last birth	rs. Months Days	Hours Min.	8. Date of Bir (Month, Da January	ay, Year)	Coui	place (State or Foreign ntry) na, S. America
	and wo		Usual Residence of 10a. State	10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
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	h the	Director	10e. Street and Nun		,,		10f. Zip Code			10g. Citizer	n of What Coul	ntry?
	23a c		9701	Armistead 1	Road			20903			U.S	.A.
	tems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	)- 14.	. Race - Americ Black, White,	
36	rs afte	by F	1 ☐ Never Marrie 3 ☐ Widowed	ed 2 Married	1 ☐ Yes 2 😿 I If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🍱 No	Specify:		S	pecify:	st Indian
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			23a. Part 1. Enter the shock, or hear	ne disease, or com rt failure. List only	plications that caused one cause on each li	I the death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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68760,	ificate be executed g physician and is the burial-transit	edical		•	d. DLa	lides	mellitus					
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Ö	the de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify) _					
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n C	Jing F	ion	<ol> <li>Manner of Death</li> <li>Matural</li> </ol>	5 Pending	28a. Date of Inju (Month, Da		ury Work	</td <td>28d. Describe</td> <td>how injury o</td> <td>occurred</td> <td></td>	28d. Describe	how injury o	occurred	
isi	Attending r death. sctor: After by the fune	licat	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b	e 29a Place of Ini	ury - At home farr	n, street, factory, office	Yes 2 □No	28f. Location (	Street and I	Number or Bur	al Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical C				f examination and	death occurred at the tir /or investigation, in my o					
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•					completed cause of d	eath (Item 23a) (1	ype, Print)	9E (.)	A3HING			
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	Registr	ar	AU	G 04 20	09 Cereua	1 B. A	action					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Den. 2009 oan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPItal ambrida Dorchstei General If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🖫 F Year) Days Hours Months 213-80-7164 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Marylan 10a State 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No **Funeral Director** orchester Mbridge 10g. Citizen of What Country? 10e. Street and Number 215 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📶 No Specify Š Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone else's home 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leatrice ၉ tdams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD, 21230 atapsco 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cambridge Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ( Metery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HENRY FUNERAL HOME, P.A.

510 Washington St. Cambr. dge, MD. 21613

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate
Interval Rethween 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final phalopath Inoxic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 No cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1□ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 143238 Lown

State Registrar 31. Date filed (Month, Day, Year)

MIL O 4 TOD

30. Name and address of person vnn completed cause of death (Item 23a) (Type, Print

dell

St. Cambridge, Ml 21413

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year FOR D **Physician** M. HESTER 711G 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES GREATER LAUREL AND REHAB. CTR. LAUREL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐M 2 ☐XF PΑ 4. 91 AUG. 174-14-2327 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County '7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "holical Exercited in ast be notified at 1 X Yes 2 □ No Director LAUREL PRINCE GEORGES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20707 14200 LAUREL PARK DR. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify. ģ 3 Widowed 4 □ Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other tha any injury or other traumatic aware JEWELERY **STORE** BOOKKEEPER 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CANDACE CHALMER DUFFY ဂ HERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 848 RITCHIE HWY., SEVERNA PARK, MD. 21146 ROBERT FORD/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-7-2009 PARKLAWN CEMETERY ROCKVILLE, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 -M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** OLD AGE /Medical Due to (or as a consequence of): **Examiner** YEARS DEMENTIA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the I IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year for L Month Day 5 Other (specify) □Yes 2XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 X Unknown CHRONIC HYPONATREMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 2 No 1 ☐ Yes 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within ? To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 210 14300 Gallant FUX LW 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 04 Registrar

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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be eximinin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical			and	ne basis of ex- manner stated	amination a	and/or in	rvestigation				he time, date		ace, and due to t	
	Σ	29b. Signature and	title of certif	er/						ense number	r		1.	Date signed (Mo	ontn, Day,Year)
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State of Maryland / Department of Health and Mental Hygiene

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**Physicia** /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination of the traumatic event, the Medical Examination of the American Examination of the traumatic event, the Medical Examination of the traumatic event, the Medical Examination of the American Examination of the traumatic event, the Medical Examination of the traumatic event, the Medical Examination of the traumatic event.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the all ending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, 15HC# Stat Registrar

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	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
n al	ELIZABETH S. GARRISON		AUGUST C	01, 2009	1:25A <sup>M</sup>
er :	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
	3612 SOUTH RIVER TERRACE	EDGEWATER		ANNE ARUN	DEL
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yes OCT. 01,1	9. Birthp Cour 917	lace (State or Foreign htry)
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rect	MARYLAND   ANNE ARUNDEL   EDGEWATE	10f. Zip Code	100	Citizen of What Cour	
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Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	den Surname)	
ဝ	RALPH E. STOVER	ANNE	McCARTHY		
		g Address (Street and Number or Ru			,
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	1 A Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LAKEMONT		5,2009 DA	VIDSONVILI	LE.MD.
	21. Signature Funeral Service Licensee	Name and Address of Facility GEO	RGE P. KAL	AS FUNERAI	HOME
	23 Famil. Enter the disease ir complications hat caused the death. Do not ent	973 SOLOMONS ISLA: er the mode of dving, such as cardiac		DGEWATER, N	1D. 21037 Approximate
	shock, or heart failure. List only one cause on each line.		,,		Interval Between Onset and Death
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Ĕ			autopsy performed	prior to co death?	mpletion of cause of
<u>ت</u>	25. Was case referred to medical	OC Diagraph Day	1 □Yes 2 🗖	No 1 □Yes	2 No
ň	examiner?  1 \( \text{Yes} \) 2 \( \text{LN} \text{No} \)  Hospital: 1 \( \text{Inpatient} \) 2 \( \text{ER/Outpatien} \)	Othor	th (Check only one)	6 DOther (Carrie	
- 4	27. Magner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how in		<i>y)</i>
	1 Hatural 5 Pending (Month, Ďay, Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rura	I Route Number,
9					
Medical Certification:	29a. Certifier (Check only one)  1. ✓ Certifying Physician: To the best of my knowledge, death and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	Mart O. Weltz	DSSM	S AU	GUST 2,200	19
	30. Name and address of person who completed cause of death (Item 23a) (Type, I			+ MD 2	83-
	MAKTIN WELTZ 7525 OFFRY 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ray CT Dr C	747401241	, MDS	0170
	AUG 03 2009 Server A.	and			
)1	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa				

			1 - For State Registrar			ertificate of	Death	Reg.		26347
	Physici /Medi		1. Decedent's Name (First, Middle  MICHAEL EDWI)	N HORNEY			A	Date of Death Month	Day Year	3. Time of Death 4:45pM
	Examir	ner	4a. Facility Name (If not institution Memorial	Hospi		Eas	Location of Death		4c. County of Deat	00+
	Funeral Director		5. Social Security Number 216-64-8112 Usual Residence of Decedent	6. Sex 1 X M 2 □ F 7. Age 56	(In yrs. last birthday Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Ye G.31,19	9. Birt Co <b>52 MAR</b>	hplace (State or Foreign untry) YLAND
	death with the Maryland sms 23a or 28a-f show	tor	10a. State 10b. County	OLINE	10c. City, Town or L					10d. Inside City Limits 1 □Yes 2▼No
	or 28	Direc	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	s 23a	eral	14762 DAY ROA	12. Was Decedent E		21636		No. of the last	USA	2 1 1 12
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ira M. dica Evanian until be rediffied at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 🙀 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ∐Yes 2 K∏ No	lispanic Origin? (Specify an, Mexican, Puerto Rica Specify:			e, etc. WHITE
15	in 72 ł	Completed	15. Decedent (Specify only highes	T	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of working f)	16b	. Kind of Business/	Industry
212	d withi giene.	Jmo;	Elementary/Secondary (0-12)	College (1-4or 5+	)	WATERMAN			SEAFOOD	
Maryland	buld be filed Mental Hygi arked other atic event, Il	To Be (	17. Father's Name (First, Middle, L GRASON HORNEY	ast)			18. Mother's Name (Fin		den Surname)	
lar)	2 sho and 1 is ma rauma		19a. Informant's Name/Relationsh				and Number or Rural Ro			Zip Code)
	1 and 2 Health em 27 i		MARY RAE EWING/ 20a. Method of Disposition	FRIEND			O, GOLDSBORO		L636 Location - City or	Town State
Baltimore,	t. Page rtment c rtant: If		1 ☐ Burial 2 <b>X</b> Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	CHESAPEAK TENTER	position (Name of ematory or other place E CREMATION	ON AUG. 4, 20		revensvil.	
Bal	permi Depar Impor any Ir		21. Signature of Euneral Service L	ticensee	F	22. Name and Addres	ELFENBEIN &	NEWNAM	FUNERAL	HOME, P.A.
	Physician		23a. Part 1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused to	he death. Do not e	nter the mode of dyin	CK ROAD, CHI Ig, such as cardiac or res In farction	spiratory arrest,	4D 21619	Approximate Interval Between Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	-,,			1	1 71000
	Examiner	-	Sequentially list conditions,	b. Due to for as a	consequence of:					
	cuted id ansit	Medical Examiner	Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events	C	in the state of the					
Ö,	tificate be executed g physician and as the burial-transit	E	resulting in death) Last	Due to (or as a	consequence of):					
68760,	cate b	dica		d						
O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending trial director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o  1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc	y		23d. Date of del Month	ivery Day Year
o,	s that gned b e deta	by P	Part II. Other significant condition	ns contributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should b	ted t	Hyperter	ision, H	yper c	holestero	/ Emia	1 Yes	2 No 3 Pr	obabiy 4 🗌 Unknown
I Records,	ding Physician: The law r h. After this certificate has be funeral director, page 2 sh	Completed						24a. Was an autopsy performed 1 □Yes 2	prior to death?	topsy findings available completion of cause of 2 \sumbox{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\}\$}}}\$}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}
of Vital	Iclan: Sertific ector,	Be	25. Was case referred to medical examiner?	I have beli		Tair	26. Place of Death (Ch			
of	Phys r this ral dir	<u>۱</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie		4 LI Nursing Home	5 Residence		cify)
on	th. : Afte	ition	Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day,		Work	y at (? (? Yes 2 □ No	Describe now ii	njury occurred	
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	ot be	y - At home, farm, s (Specify)		28f.	Location (Stree) City or Town, S	t and Number or Ru tate)	ral Route Number,
	he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one)  Certifying  Certifying  Certifying	Physician: To the best of examiner: On the basis of and manner state	examination and/or i	ath occurred at the tir investigation, in my o	ne, date and place, and pinion, death occurred a	due to the caus t the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
		M	29b. Signature and title of certifier	1 Dente	-, mD	29c. License	e number +7492	29d.	Date signed (Month	n, Day, Year) 3, 2w9
	ans.		30. Name and address of person w	tho completed cause of dea	ath (Item 23a) (Type	Print)	Dr. E.	ston	ms:	2/60/
	Sta		31. Date filed (Month, Day, Year)	33. Registrar	's Signature		,			-
DH	Registr MH 17 Rev 1/2		AUG 4	2009 Comme	p. 190	are .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** Walter Louis 8:28 a M Horner August 2, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours NXM 2□ F 500-24-7434 83 April 24, 1926 Missouri Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Kensington Director Maryland Montgomery with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 USA 3611 Sandy Court death \ by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1944-46 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n, any Injury or other traumatic event, the Mental once. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Logistics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene A. Konrad Frederick Horner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 Sandy Court, Kensington, MD 20895 19a. Informant's Name/Relationship (Type. Print) Eleanor Horner/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Aug. 6, 1 ■ Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2009 Silver Spring, Maryland Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiorespiratory Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to hime dials cause. Enter Underlying Cause (Disease or injury that initiated events Juli to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit Elevated Cholesterol resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Atherosclerosis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🖾 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L t 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier D0061146 August 4, 2009

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

Anjana Dhar, MD

AUG 04 2009

DHMH 17 Rev 1/2001

10301 Georgia Avenue, #203, Silver Spring, MD 20902

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

			for State Registrar	State o	f Maryland	•	artment o			ınd Me	ental H	ygien Reg. N	21114	26349
			Decedent's Name (First, Middle)	e, Last)							2. Date of [	Death		3. Time of Death
	Physici		Lillian		Hersh	1					Month July	31,	2009	11:20 A M
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Tov	wn, or Lo	cation of	f Death			c. County of Dear	th
			Brighton Garden	ns at Fri					hase				Montgom	<i>y</i>
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Months D		f Under 2 Hours	Min.	8. Date of E (Month,	Birth D <i>ay, Year</i>	·) Co	thplace (State or Foreign buntry)
	Director		118-58-6411 Usual Residence of Decedent	1	97	115.					Aug.	27,	1911 New	York
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary -f sh	į	Md. Monts	omery	C	hevy (	Thaca							1⊠Yes 2□No
	r 28a	Director	10e. Street and Number	omery		nevy (	10f. Zip Co	ode				10g. C	itizen of What Co	ountry?
	be filed within 72 hours after death with the Maryland tal Hygiene.  id other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be redflied at	a D	5555 Friends	hin Blvd				2081	5				U.S.A	
	ems	Funeral	11. Marital Status		edent Ever in U.S	3. 13.	Was Deceden			gin? (Spec	cify Yes or I	No-	14. Race - Ame Black, Whit	
õ	after or it		1 ☐ Never Married 2 ☐ Marr	ied 1 □Yes If Yes, Gi	2 XNo ve		1 □ Yes 2 🛭		Specify:	, , , , , , , , , , , , , , , , , , , ,	,,		Specify: Wh	
15-0036	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or D	ates:							4.01-		
က်	"nat	Completed	15. Deceden (Specify only highe	's Education of grade completed)		(Give	dent's Usual ( kind of work ( DO NOT use i	ocupation done duri retired)	on ing most	of working	g	160.	Kind of Business	moustry
7	filed within Hygiene. other than "	mc.	Elementary/Secondary (0-12)	College (	1-4or 5+)		nemaker						Own Home	
Ö	e filed yall Hygin other vent, III	Be C	17. Father's Name (First, Middle,	•			iciia ker		B. Mother	r's Name	(First, Midd		n Surname)	·
yland	ld be lenta ked (	To B	Samuel Berk						Cla	ra G	ruen			
	ges 1 and 2 should be fi it of Health and Mental H If item 27 is marked ot or other traumatic ever	-	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address (S	treet and	d Numbe	r or Rural	Route Nur	nber, City	or Town, State,	Zip Code)
2	and 2 ealth a n 27 is		Stephen P. H	ersh, M.D	(son)	421   Gait	Kent S hersbu	quar	e Ro Marv	ad Zland	208	78		
o C	of He		20a. Method of Disposition	<b>2</b> □2 - 16	20b. Pl	ace of Dispo	osition (Name matory or othe Garde	of er place)	1.		ate	20c.	Location - City or	Town, State
saitimore,	permit. Pages Department of Important: If it any injury or o once.		1  Burial 2  Cremation 4  Donation 5  Other (S		State	Sharon Ce	Garde metery	ns		2009	,,	Va	lhalla.	New York
ä	permit. Departi Imports any inji		21. Signature of Funeral Service	Dicerse	)	22	2. Name and	Address				unera	al Home	
ננ	20 E # 9		Hemys	Verl	moo215	- 22	22 Wis	cons	in A	ve.,	N.W.	Was	h., D.C.	20007
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	caused the death each line.	. Do not en	ter the mode of	of dying,	such as	cardiac or	respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a Brea	st Cance	er								Months
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	ence of):								
	LAGIIIIICI	_	Sequentially list conditions,	b	(or as a consequ	anas of):								
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	ence or).								
ڔ	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c Due to	(or as a consequ	ence of):								·
2/60	ficate be executed physician and sthe burial-transit	dical E		d										
ρ	death certificate e attending phys d for use as the	edic		u								T		- 100
X ROX	h cer endin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregnal	ncy	☐ Ectopic pred	nanov				- 1	23d. Date of de	,
מ	deat ne att	icia	in the past 12 months? 1 □ Yes 2 🖾 No		nant at time of de		Other (spec					- ]	Month	Day Year
7. O	w requires that the death certifice been signed by the attending should be detached for use as	Physician/Me	9 Unknown								T			
<u>v</u>	esth iigned bede	þ	Part II. Other significant condition	ons contributing to d	eath but not resu	lting in the u	nderlying caus	se given i	in Part I.					o the cause of death? robably 4 ☐ Unknown
cord	requii een s rould	Completed									11	Yes	ZMŽINO 3∐ L	
d)	has be 2 st	nple				-					24a. W	topsy	prior to	utopsy findings available completion of cause of
	: The cate h page	S										rformed? ≥ 2 <b>X</b> N		s 2 No
	ding Physician: The law h. After this certificate has funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Other:			(Check onl			
5	Phys rthis raldii	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2 1	ER/Outpatier 28b. Time o			4 LI Nui				6 ☐ Other (Spe ury occurred	ecify)
_	ding h. After fune	흲	1 ☑ Natural 5 ☐ Pendin	g (Mor	nth, Day, Year)	Injury	M 250	. Injury a Work? 1 □ Ye:	" s 2□N		ou. Descrit	ic now my	ary occurred	
DIVISION	Atten deat ctor: y the	ertification:	3 ☐ Suicide 6 ☐ Could		of Injury - At hoing, etc. (Specify	me, farm, str					8f. Location	(Street a	and Number or F	ural Route Number,
2	al or Attending Is after death. I Director: After din by the funer	erti	4 ☐ Homicide determ	build	ing, etc. (Specify	1)					City or	Fown, Sta	ite)	
	spita nours neral / fille	a C	29a. Certifier 1 Certifyir	g Physician: To the	e best of my know	wledge, deat	th occurred at	the time	, date an	d place, a	and due to t	he cause	(s) and manner a	is stated.
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	ledical	(Check only 2 Medical one)	Examiner: On the l and mar	pasis of examinat mer stated.	tion and/or in	vestigation, ir	n my opin	nion, deat	th occurre	ed at the tin	ne, date a	na place, and du	e to the cause(s)
	Vithi To the	M	29b. Signature and title of certifie		A.		29c. L	icense n	umber			29d. D	ate signed (Mon	th, Day, Year)
	10		1/h	COR	M		D:	3945	6			Aug	gust 3,	2009
	•		30. Name arter address of person											
			Lila McConnell,	MD 5530	Wiscons	sin Av	e. Che	vy C	hase	, MD	2	0815		
	Sta Registr		31. Date filed (Month, Day, Year)	2009	Registrar's Signal	dear	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Reginald Windsor 2009 10:30 a<sup>™</sup> King August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Dorchester General Hospital Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 XM 2 ☐ F 21, 1934 74 Maryland 218-30-8022 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County items 23a or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Medical Exandred", ust be notified at 1 ☐ Yes 2 XNo Toddville Director MD Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2572 Toddville Road 21672 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1952–55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Hwg, Reginal C Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mechanic automotive 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Love Geisbert William Howard King မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2572 Toddville Road, Toddville, MD 21672 Evelyn King wife Health em 27 I permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. or other 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/5/09 Zion Churchyard Toddville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee \_ 1\_ ) 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final UPA **Physician** NAU disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, having to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the irector, page 2 sl autopsy performed? 2 DH6 Bease 0 1 ☐ Yes this certific al director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Appatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☐ Hatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ours after death.

neral Director: Af
filled in by the fur within 24 hours a

To the Funeral C

completely filled

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifier empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

ar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

determined

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Klontz Anne S. July 28, 2009 5:29 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 8204 Driscoll Drive Bowie Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Hours Days 1 ☐ M 2 💢 F Yrs. 58 136-42-8294 June 9, 1951 New Jersey **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Bowie MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 8204 Driscoll Drive 20720 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Office Manager SK Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental ! permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Penn Fulton Spitzer Jean R. Ruppel ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8204 Driscoll Drive, Bowie, MD 20720 Donald D. Klontz/Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 8/3/2009 |Silver Spring, MD 21. Signature of Funer Socice License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2XNo P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**K** No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ after death. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral I 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7/29/2009 D23743 30. Name and address of person who completed cause of death tem 23a) (Type, Print) Martin Weltz 7525 Greenway Court Drive, Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) State AUG 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2009 Arline Μ. Lang July 29. 3:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Anne Arundel Harwood 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/3/ 1916 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 X 064-38-8952 92 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f show event, the Medical Expressor must be netified at New York Erie 1 ☐ Yes 2 X No Williamsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4230 Clardon Drive 14221 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify. Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 At Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Decker Thomas McHugh Mary ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Riviera Dr. Altlanta, GA. 30012 Robert M. Lang/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Kalas Crematory 5 Other (Specify) 7/31/2009 Edgewater, Maryland 4 □ Donation 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Ameral Service Licenses 2973 Solomons Island Rd. Edgewater,MD. 21037 110 23a. Part f. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on f. ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): requires that the death certificate be executed buriaf-transi Exami that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) the detached 9 Unknown É signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy perform 1 □Yes 2 No Physician: 25. Was case referred to medical examiner? MANDRIN Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) TOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death e Hospital or Attending Pl 1.24 hours after death. e Funeral Director: After the letely filled in by the funeral 28a. Date of Injury (Month, Day, Year) BRUGH 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 TYes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated.

State

Registrar

29b. Signature

31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

			For State of Ma	-	partment of Hea Pertificate of Dea			ne No.2 0 0 9	26353
			Decedent's Name (First, Middle, Last)				ate of Death	Day Year	3. Time of Death
н	Physicia /Medic		Mary L. Mount				gust 1	2009	6:36 P M
and it	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	ation of Death		4c. County of Death	
			Shady Grove Adventist Hosp		Rockvi			Montgon	
	Funeral Director		220-38-2286 1□M 2XF	e (In yrs. last birthday 88 Yrs.	y) If Under 1 Year   If U Months Days He	ours Min. (A	ate of Birth Month, Day, Ye tober 2	9. Birth Co. 2,1920of (	place (State or Foreign Intry) District Columbia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	Location				10d. Inside City Limits
	Maryl f sho	호	MD Montgomery		Gaithers	burg			1 ☐ Yes 2 📉 No
	the 788	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?
	h with	a D	415 Russell Avenue		20877			United S	States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exprining must be notified at once.	by Funeral I	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent in Armed Forces?  1 Pes 2 No If Yes, Give year or Dates:	1	B. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 No Sp	nic Origin? (Specify Y lexican, Puerto Rican pecify:	es or No- , etc.)	14. Race - Amer Black, White Specify:	
<u>0-</u> 0	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occupation	l s most of working	168	b. Kind of Business/l	ndustry
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2	ed wil	S	4		Homemake			Own Home	
pu	be fill ntal H rd oth even	Be	17. Father's Name (First, Middle, Last)		18.	Mother's Name (Firs		den Surname)	
yla	ould I Mer narke	ဥ	Roberts E. Latimer			Ida Ja			
Mar	12 sh hand 7 is m traum		19a. Informant's Name/Relationship (Type. Print)  Michael S. Mount / Son	- 1	iling Address (Street and I				
e,	1 and Healt em 2		20a. Method of Disposition		Norbeck Roa	d, Silver		S. MD 2090 Location - City or T	
Baltimore, Maryland 21215-0036	trnent of trant; If it tant; If it		1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metropol Crem	ematory or other place) itan atorv	August 2009	3, A1	exandria,	Virginia
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licensee  NACY H. Kruse M011	17 İ	22. Name and Address of DeVol Funera G	Facility 1 Home, 10 aithersbur	D East	Deer Park 20877	Drive,
П			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	c obst	notice P	Imorre	Die	seree.	Onset and Death
	/Medical		resulting in death)	a consequence of):		-			Vers
	Examiner		Sequentially list conditions b.						
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
)	and -trans	Examiner	that initiated events	a consequence of):					
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68760,	ficate be executed physician and s the burial-transit	edical	d						
O. Box (	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	B			23d. Date of deli Month	very Day Year
σ.	that the ed by detac		Part II. Other significant conditions contributing to death be	ut not resulting in the	underlying cause given in	Part I. 2	23e. Did tobac	co use contribute to	the cause of death?
ords,	requires een sign oould be	ted by					1 X Yes	2 No 3 Pro	obably 4 Unknown
Division of Vital Records,	The law ate has b	Completed					24a. Was an autopsy performed □Yes 2 D	prior to o death?	copsy findings available completion of cause of
/ita	cian; ertific ector,	Be (	25. Was case referred to medical examiner?		26.	Place of Death (Che			
)t	hysi this c	ဥ		ent 2 ER/Outpati		I ☐ Nursing Home			rity)
sion (	ending F sath. or: After he funer	Certification:	27. Manner of Death  1  Natural 5  Pending (Month, Da) 2  Accident investigation	iry 28b. Time ly, <i>Year)</i> Injury	Work?	28d. [	Describe how i	injury occurred	
Ž	salor Att safter de al Directo ed in by t	Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	ury - At home, farm, s c. <i>(Specify)</i>	street, factory, office		ocation (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	ie Hospi 24 hour ie Funer	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or	ath occurred at the time, of investigation, in my opinion	date and place, and d on, death occurred at	lue to the caus the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Comp.	Me	29b. Signature and title of certifier		29c. License nur	4.0		Date signed (Month	
	10		Runn		040	1157	1	August dr	9,3008
			30. Name and address of person was completed cause of d	leath (Item 23a) (Type	e, Print)				
_	(1)		IR BERGER M.D. 1301	7 boks	Road, Ro	ckville, r	wedler	19 9082	4
	Sta Registr	-	31. Date filed (Month, Day, Year) 22. Registra	ar's Signature	KI.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month August 1, Day 2009 **Physician** 6:30 a M William Allen Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**XX**M 2□ F 218-20-0217 85 28, 1924 Virginia May Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, Included Evanian in ust be notified at 1 ☐Yes 2 X No Director Maryland Montgomery Kensington death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11106 West Avenue USA 20895 Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other thems any injury or other trained. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No δ Specify: 3 Widowed 4 Divorced Year or Dates: WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Allen Miller Minnie Wilt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia E. Miller/Wife 11106 West Avenue, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State August 2009 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiac Arrest Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter Uniority in Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Sepsis resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) o. ☐Yes 2☐No 9 D Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 Yes after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Main Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient Certification: To 28b. Time of 27, Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

completely filled within 2 To the 2 12+1

24 hours a

the

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 04

30. Name and address of person who comple

Harold Lawson, MD

29b. Signature and litle of certi

29a. Certifier

1500 Forest Glen Road, Silver Spring, MD 20910 3 Registrar's Signat

cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D67589

29d. Date signed (Month, Day, Year)

August 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vear **Physician** 3:00 a M Jane Rima August 02 2009 Meh1 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 14917 Wellwood Road Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛛 F 144-40-3819 63 Director October 17, 1945 Pennsylvania Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show must be notified at 1 ☐Yes 2 K No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any hjury or other traumatic event, the "Mulcal Event in critical burn once. 14917 Wellwood Road 20905 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 ☑ No 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Human Resources Pepco 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maximilian Muenzer Ruth Leah Krasno ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14917 Wellwood Road, Silver Spring, Maryland 20905 Georg Michael Mehl - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 08/04/2009 Judean Memorial Gardens Olney, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signatur of Fun al Service Licen Jaker 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 years Non Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

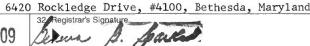
Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signatur and title of ce 29c. License number 2

State

State 31. Date filed (Month, Day, Year)
Registrar
AUG 0 4

Ralph Boccia, M.D.,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

D29675

August 3, 2009

			For State of Mail  1 - State Registrar	ryland / Depa <i>Cei</i>	artment of He <i>rtificate of D</i>			ene g. No. a a a a a	00050
Ī	Physicia	an	1. Decedent's Name (First, Middle, Last)  Martin J. McDonnell	-			2. Date of Death	2 <sup>Day</sup> 2009 <sup>Year</sup>	3. Time of Death 9:54 AM
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	nagase	4c. County of Death	J.J4 Am
2.6			Shady Grove Adventist Hospi  5. Social Security Number   6. Sex   7. Age	tal (In yrs. last birthday)	Rockvill  If Under 1 Year	.e If Under 24 Hrs.	8. Date of Birth	Montgome	ry place (State or Foreign
ı	Funeral Director		123–16–2876 1 → M 2□ F	81 Yrs.	Months Days	Hours Min	Aug. 9,	1927 New	York
	land ow			10c. City, Town or Lo		-		1	10d. Inside City Limits
	e Mary 8a-f sh iifi a	Director		Gaithersb	urg				1 □Yes 21 No
	with th	I Dire	10e. Street and Number 140 Chevy Chase Street, #30	6	10f. Zip Code 20878		10	ng. Citizen of What Coul United Sta	
	r death	Funeral	11. Marital Status  12. Was Decedent Ev Armed Forces?		Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	can Indian,
036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Evanning must be notified at	by	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 ☐ Mod 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □Yes 2X No	Specify:		Specify: Whi	
21215-0036	72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat kind of work done du	ion ring most of worki	ing I	6b. Kind of Business/In	
2121	l within giene. r than'	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Fria	DO NOT use retired) <b>r</b>			Community	
and	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)  John J. McDonnell		1	8. Mother's Name		,	
aryli	should and Me s marke umatic	To	19a. Informant's Name/Relationship (Type. Print)			nd Number or Rura	al Route Number,	City or Town, State, Zij	
e, M	and 2 lealth a lm 27 is		Anne G. McDonnell (Wife)		<u>-</u>			thersburg,	
altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the "Macter Evanning must be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cres Calvary	natory or other place)		st 8.	oc. Location - City or To Queens,New	
Balti	ermit. I epartm nportai ny Inju		21. Signature of Funeral Wool inches	22	2. Name and Address	of Facility DeV	ol Funer	al Home,	
			23a. Part 1 t the disease, or complications that caused the	ne death. Do not en				aithersburg st,	Approximate
y	Physician		shoty/or eart failure. List only one cause on each line imme i Cu se Final disease or condition  Aspirati	on Pneumo					Interval Between Onset and Death
E.	/Medical Examiner		resulting in death)  Due to (or as a Sepsis	consequence of):					
	P #	ner	Sequentially list conditions, if any leading to immediate b.	consequence of):					
5	execute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a	consequence of):					
68760,	death certificate be executed e attending physician and id for use as the burial-transit	edical E	d						
39 x	eath certifica attending ph for use as th	/Med	IF FEMALE: 23c. If yes, outcome o	f pregnancy				Old Date of deliv	
O. Box	death he atter	Physician/M	in the past 12 months?  1 Yes 2 No  1 Yes 2 No	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deliv Month	Day Year
<u>Р</u> .	that the de ed by the detached		9 ☐ Unknown  Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contribute to t	the cause of death?
rds,	w requires that been signed I should be deta	ed by					1	s 2 No 3 Pro	bably 4 🖾 Unknown
Vital Record	e law re has be je 2 sho	Completed					24a. Was an	prior to co	opsy findings available ompletion of cause of
ta E	sician: The la certificate ha irector, page 2		25. Was case referred to medical			26. Place of Death	perform 1 Yes 2		2  No
of Vi	Physici this cer al direct	To Be	examiner? 1 ☐ Yes 2 ☒No Hospital: 1 ☒ Inpatien	t 2 ER/Outpatie	nt 3 DOA Other	4 ☐ Nursing Ho	me 5 Reside	nce 6 Other (Speci	ify)
Ou	nding Ph th. : After th e funeral	tion:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day,	Year) 28b. Time o	Work?	at es 2 □ No	28d. Describe hor	w injury occurred	
Division of	or Attencate death Director:	ertification: T	a Displayer 6 Displayer he	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str City or Town	eet and Number or Run State)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	0	29a. Certifier 1X Certifying Physician: To the best of	my knowledge, deat	h occurred at the time	e, date and place,	and due to the ca	ause(s) and manner as	stated.
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner state						
	1 2 oo	2	29b. Signature and title of certifier	10	29c. License	5132		August 2, 2	
	•		30. Name and address of person who completed cause of der Wei Zhang, M.D., 9901 Medic	ath (Item 23a) (Type,					
	Sta	te	Od Date filed (Manth Day Vers) 20 Magistras	'a Cianatura					
	Registr		AUG 04 2009 Drum	s Signature	who				

			1 - For Amend It			Cei	rtificate of	Deam			Reg. No.	2009	250	35/
	Dhusisi		1. Decedent's Name (First, Middle, I							2. Date of De Month		Year	3. Time of [	Death
	Physici /Medio		Shirley A	Ann Mye	ers					July	31	2009	4:15	A M
	Examin	er	4a. Facility Name (If not institution, g	give street and nun	nber)		4b. City, Town, o	or Location of	of Death		1	ounty of Deat		
			Anne Arundel Med 5. Social Security Number 6.			to a fit at to V	Annapol		Od Dro I			ne Aru		
	Funeral Director		219-30-2555	. Sex 1 □ M 2 💢 F	7. Age <i>(In yr</i> s. 76	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 05-05-	tn -1033	9. Birti Co Mar	hplace (State or untry) 'y Land	Foreign
			Usual Residence of Decedent		/ 0					05 05	1933	Hai	yrand	
	how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City	Limits
	e Mar	Director	MD Anne An	rundel			Annapo1	lis					1 X Yes	2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Co	untry?	
	ath w		1501 West Street				21401					USA		
	er de items	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	- 14	. Race - Ame Black, White		
36	rs aft	by F	1 M Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes If Yes, Giv Year or Da	e		1⊡Yes 2∏XNo	Specify:			S	pecify:		
Ö	tural stural	pe	15. Decedent's		nes.	16a Dece	dent's Usual Occur	nation			16h Kind	wh of Business/l	ite	
212	in 72 in "ins Weath	plet	(Specify only highest g	grade completed)	4== 5 - )	(Give	kind of work done DO NOT use retire	during mos	t of workin	g	TOD. TITLE	Of Dusiness/i	industry	
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g	al Hy l othe	Bec	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Name	(First, Middle,	Maiden Su	ırname)		
<u>yla</u>	wild b Ment arked atic e	2	Harvey Fenton	n Myers	s, Sr			Мy	rtle	Virg	ginia	Carr		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evarings must be notified at once.		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number	er or Rura	l Route Numb	er, City or 7	own, State, 2	Zip Code)	
<u>√</u>	and lealth m 27 her tr		Joan Carr Myers	<u>, sister</u>			Roland A		Apt.	503, I				
0	ges 1 t of H If Ite or ot		20a. Method of Disposition 1   Burial 2 ☐ Cremation 3	☐ Removal from S	20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Di	ate	20c. Loca	tion - City or	Town, State	
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Ba	permit Depar Impor any in		21. Signature of Funeral Service Lic	ensee	7		2. Name and Addre							
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	ly one cause on ea	ich line. <b>Sub</b>	n. Do not ent odura1	er the mode of dyli <b>Hemaţoma</b>	ng, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betw Onset and D	
me.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. <del></del>	RECE			10:20	114	-			4 da	
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Was case referred to medical examiner? 1   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 3   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 5   Yes 4   Yes 5   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Y	b. 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 **Physician** 2con /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tospital 1601 Edistan at 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. Director JUNE 14 1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Practical Evertination to notified at once. Director 1 ☐ Yes 2 ☑ No Dorches enna 10e. Street and Number 10g. Citizen of What Country? 869 2 USA Funeral Neck 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No ģ 3 Widowed 4 Divorced Bjack

16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Road-Mainte Nance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be MOLOCK # ဂ္ Wesley Hazel Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fork Neck MD. 21869 S-MOLOCK Deloves Koad ienna 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 81 7/09 Fork Neck, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Figure List only one cause on each line. Cambridge, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastano Prustate (ancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any lating in a lating cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a nonsequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) iis certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy After this certificate 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 | Pending investigation 1 ☐ Yes 2 🗆 No after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

State Registrar 29b. Signature and title of certifier

AUG 0

David

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Redistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29, 2009 Year **Physician** Colleen Margaret Messer 1:23  $A^{M}$ July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mandrin Chesapeake Hospice House Anne Arundel Harwood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Days Year 1 □ M 2 🔼 F Months Hours 52 Director 004-84-0870 New Zealand June 25, 1957 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5835 Auth Road 20746 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 If Yes, Give 2 **X**No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No ģ Specify 3 ☐ Widowed 4 X Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Financial Title Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Angus William Apes Sybil Heather Clark ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sallie Mae Dozier/Executor 5905 Kirby Road, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/31/2009 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland Signature of Fundal Sovice Linensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 A No 1 □Yes 2 🗆 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 XNo Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27 Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Da

Martin Wiltz

7525 Greenway CT Dr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenbelt, MD

7/29/2009

D23743

State 31. Date filed (Month, Day, Year)
Registrar AUG 03 37

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 Year Day Charles Oliver Mills 2 10:49 a.M August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Dorchester 409 Leonard Lane Cambridge 8. Date of Birth (Month, Day, Year)

Jan. 11, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 11 M 2 □ F 86 1923 Maryland 216-14-9518 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Leonard Lane 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ ¥No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrician construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie C. Mills Beryl Horseman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gladys Mills wife 409 Leonard Lane, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 8/5/09 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

permit, Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any injury or other traumatic event, the Medione.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

than "natural", or items 23a or 28a-f show he Medical Examiner πust be notified at

death with

filed within 72 hours after

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division or Vital Records,

Director

Funeral

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Completed

Be

The law requires that the death certificate be executed and burial-trai attending physician for use as the buria ed by the a signed I page 2 s certificate Physician:

Physician/Medical Completed by Be

Medical

director, this

Hospital or Attending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Examiner Certification: To funeral

25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined 4 Homicide

1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Year) AUG 0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug 7, <sup>Day</sup> 2009 **Physician** Katie Miller 12:05am Alberta /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany 19 Somerville Avenue Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Ye Jun 11, . 1940 **Funeral** Min. 1 □ M 2 □ ¥ Months Days Hours 234-62-2729 69 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a live item in a miner must be notified at MD Allegany Cumberland Director 1 ☐Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 19 Somerville Avenue 21502 USA Funeral 2 should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items 23. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Army & Air Force Post Exchange permit. Pages 1 and 2 should be filet.
Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumant once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James L. Hook Cora Leona Whitacre McDonald ည 19a. Informant's Name/Relationship (Type. Print)
Curtis Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Somerville Avenue Cumberland MD 21502 husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veteran's Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/2009 Flintstone MD 21. Signatur of Fun ral Service Licens e 22. Name and Address of Facility all Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Caus (Final disease or cond ion resulting in dear) **Physician** 31.30109 Braincore /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapping stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SETON DR. ( UMBERLAND MD a 1502 ZAMAN M.D 32. Aegistrar's Signature 31. Date filed (Mont State Come Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Maric Norw /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner New Hope Assisted Living Cumberland Allegany 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Hours Min 218-12-5200 07/28/1922 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene important; in items 23a or 28a-1 show amportant; if item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Eventine is ust be retified at 2008. MD Allegany Cumberland Director 1 □¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11609 Bierman Drive 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □Xo Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Laundry Department Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Shipley Gertrude Snyder Shipley ဥ 19a. Informant's Name/Relationship (Type. Print) Linda Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10149 Reed Lane Ellicott City MD Pages 1 and 2 s ment of Health ar daughter MD 21042 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 8/15/2009 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Iff Fullity ral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** Altherner Mease Tyeurs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying iner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exam and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) detached 9 Unknown page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate I performed? 1 ☐Yes 2 ☐No After this certific funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be

Division of Vital Records, P.O. Box 68760,

Registrar

State

filled in by

completely

Medical

DHMH 17 Rev 1/2001

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

08/13/09

Kelly Road Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

determined

Jerry Ettervey FUP-C CRNP

Harrey Fup-c

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

			For State Registrar		State of	Marylar		artment of r <i>tificate o</i> i	Health and f Death	Mental Hy	giene Reg. No. 🤉 [	POO	26363
			1. Decedent's Name (Firs	st, Middle, Last	t)					2. Date of De		Year	3. Time of Death
	Physicia /Medic		Bridget	Nwa	anyanw	u1	Ndife			July			2340 <sup>M</sup>
A. A.	Examin		4a. Facility Name (If not in	-					or Location of Dea	th		nty of Death	
-			Shady Gr  5. Social Security Number				. last birthday)	ROC	kville	8. Date of Bi		ntgon	lery  blace (State or Foreign
	Funeral Director		212-85-2		™ 2 <b>⊠</b> F	57	Yrs.	Months Day		2/16/	952	Nic	jeria
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	3a or	Funeral Director		idael:	ine Dr	ive		2086			Ni	geria	1
	death	ner	11. Marital Status		12. Was Dece	dent Ever in L	J.S. 13.	Was Decedent of	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No	D- 14. FI	ace - Americ	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Macheal Examiner mats the notified at once.	þ	1 ☐ Never Married 2		1 ∐Yes If Yes, Giv Year or Da	2 <b>⊠</b> No e		1 ∐Yes 2 <b>⊠</b> N		no moan, etc./	Spec	D.7	ack
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	nit. Pa artme ortant injury e.		4 ☐ Donation 5 ☐		-//	S		<mark>/'s Cen</mark> a:NamarandAdo	ı <u>. ¦8/2</u> У••R1FNALD	8/2009			Nigeria
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П			23a. Part 1. Enter the dis shock, or heart fail	ase, or comp	olications that ca	aused the dea	th. Do not en	ter the mode of d	lying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
Mary .	Physician		Immediate Cause (Final disease or condition		a Pul	monar	y Embo	olism					Onset and Death
1	/Medical Examiner		resulting in death)		Due to (	or as a conse	quence of):						
L		er	Sequentially list condition if any, leading to immedia	ns, ate	b	or as a conse	quence of):						
	cuted nd ransit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	C.								
5	e exe vian ar urial-t	EX	resulting in death) Last		Due to (	or as a conse	quence of):						
	ficate be executed physician and s the burial-transit	edical		•	d								
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5	v requ	eted								24a. Wa			opsy findings available
ב ב	ding Physician: The law requires that the death certif h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	Completed								- auto	opsy ormed?	prior to co death?	impletion of cause of
פ	an: T tificat tor, pa	Be Co	25. Was case referred to	medical					26. Place of D	1 ☐ Yes eath (Check only	2 MNo one)	1 ☐ Yes	2 ∐No
5	nysici nis cer direct	To B	examiner? 1 ∐ Yes 2 <b>∑</b> No		Hospital: 1 🔀 I	npatient 2	☐ ER/Outpatie	nt 3 DOA	Othor:	Home 5 ☐ Res		Other (Spec	ify)
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2	• Attendier death. rector: / by the fu	icati	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be		of Injury - At I	nome farm st	M 1 reet, factory, offic	□Yes 2□No	28f Location	(Street and No	mher or Ru	al Route Number,
2	after after Direct d in by	Certification:	4 ☐ Homicide	determined	buildi	ng, etc. (Spec	ify)	oot, idetory, onle			wn, State)	inser er rie.	arrivation tallings,
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Funeral Director		5. Social Security N 220-09-21	lumber	6. Sex	M 2X1F	7. Age	(In yrs. la	st birthday Yrs.	/) If Uno Month	ler 1 Year s Days	If Unde Hours	r 24 Hrs. 8 Min. 1	B. Date of Bi (Month, D .0/16/	rth <i>ay, Year</i> 1918	9. Wa	Birth; Coul	olace (State ntry) ington	or Foreign
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Attending Physician: The law requires that the death cer reath. ector: After this certificate has been signed by the attendit by the funeral director, page 2 should be detached for use	Completed												24a. Wa aut per 1 □Yes	opsy formed?	prio dea	r to co th?	opsy finding ompletion of 2 \Begin{array}{c}\text{No}	s available cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** 01iver 9:28 A. Charlotte Jean July. 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Genesis Health Care, Severna Park Severna Park If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. (Month, Day, Year) 09/08/1929 1 □ M 2 🗓 F Pennsylvania 174-24-8849 79 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director Calvert Prince Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20678 U.S.A. 626 Patuxent Reach Drive 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 ŪNo Specify. white Specify: ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Erdman Richard ٧. Wetzel Ella ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traunonce. 751 Springbloom Drive, Millersville, MD 21108 James D. Oliver, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crematory 08/01/2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Standline of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical as attending esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ Month Day Yea in the past 12 months? 1 ☐ Yes 2 ☐ Ho 5 ☐ Other (specify) signed by the a P.O. 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐Yes 2 ☐No 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only o e) Be Hospital: Other: <sup>2</sup> <del>2</del> No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending Pi lours after death. neral offector: After t Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral of completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one)

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 03 2009

29b. Signature and title of certifier

30. Name and address of person wh

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

back

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#260cmMD, 8/4/09, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar **Physician** 2061 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Co. nty of Death **Examiner** VILLE ROWN 5 8. Date of Birth (Month, Day, Aug. 5, If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1920 1 □ M 2 1 F Days Hours Min. New York 577-12-9500 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Prince George's Chillum 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 805 Rittenhouse Street 20783 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 273No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. 1 Yes 21 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White ģ Specify. 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 Is marked other than any Injury or other traumatic event, Item Aponce. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bruno Kotulski Mary Kwiecinska ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine M. Pierpoint/Daughter 21160 New Hampshire Avenue, Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State July 31 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DVANC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown á as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? Yes 2 No 2 No 1 ☐ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only ou-) Son's residence Hospital: Other: 4 \(\superstruct{\substraction}{\substraction}\) Nursing Home 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b Time of 5 Pending investigation Natural hours after death 2 ☐ Accident 1 TYes 2 □ No filled in by the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifie

State Registrar 30. Name and

31. Date filed (Month, Day,

Year.

AUG 04

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200<sup>Ye ar</sup> **Physician** August 03, 7:05 A M Eric Christopher Quinn /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death **Examiner** Gaitheryburg 2207 Comer If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days 1/XM 2 □ F 14, 35 Iowa Director 479-86-8436 July 1974 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Expresser must be notified at 1 ☐ Yes 2 X No Directo Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 United States 17707 Amity Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Salesman permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othe any injury or other traumation. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Maurek Francis Ouinn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17707 Amity Drive Gaithersburg, MD. 20877 Mary Quinn (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 04 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2009 4 Donation 5 DOther (Specify) Alexandria, Virginia ture of Funeral Service Lig 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final **Physician** robable m disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician hed for use as the burial IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 □ Yes 2 No 1 □ Yes 2 **J** 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No the 1 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital
within 24 hours a
To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifig Dos 2003 MOME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/2 BRECHER no omE 31. Date filed (Month, Day, Year) egistrar's Signature 32 State AUG 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KENNEDY CROMWELL RICE JULY 31, 2009 07:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1174 SAINT GEORGE DRIVE ANNAPOLIS ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 1**▼** M 2□ F 37 WASHINGTON, DC Director 215-82-7506 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evaminer must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1174 SAINT GEORGE DRIVE 21409 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FINANCIAL PLANNER CREDIT UNION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental ဂ RICHARD CROMWELL RICE MARY ANNA BROOKE permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m any Injury or other traum. once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIE ANDERSON RICE/WIFE 1174 SAINT GEORGE DRIVE, ANNAPOLIS, MARYLAND 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION **AUGUST** 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 STEVENSVILLE, MARYLAND CENTER 22. Name and Address of Facility FELLOWS, HELFENBEIN ALCREMATION AND FUNERAL CARE, P.A., 814 ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licensee AND Will Elson M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANAPLASTIC ASTROCYTOMA 32 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) P.O. I ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely i and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D23683 JULY 31, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROSSMAN, M.D., STUART A. JOHNS HOPKINS CANCER CENTER, BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

DHMH 17 Rev 1/2001

09-05957 Qihong Sum

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 29, 2009 Year 1909 hrs Medical Examiner Qihong Sun 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery 16660 Crabbs Branch Parkway Way Derwood 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** 5. Social Security Number 230-99-6701 Nov. 6, 1974 Country) China Director 34 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Derwood Maryland Montgomery 28a-f shov or items 23a or 28a-f shormust be notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7603 Moccasin Lane 20855 China the Pages 1 and 2 should be filed within 72 hours after death with the 1 truent of Health and Mental Hygiene -tant: If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be motified. 這 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Asian Specify Divorced f Yes, Give Year Yes 2 X No specify: Widowed <u>م</u> 16b. Kind of Business/Industry University of Maryland 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) ted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Biotechnology Inst. Comple Baltimore, MD 21215-0036 5+ Research Scientist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fengcui Fang æ Chongjin Sun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1544 International Ct., #H6, Manhattan, KS 66502 Jianxiu Yao (Spouse) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 X Cremation Aug. 14, Metropolitan Alexandria, Virginia Removal from State Department of Important: I 2009 Ather\_ Crematory Donation 5 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Fune ervice Lice 1100689 10 E. Deer Park Dr., Gaithersburg, MD 20877 Approximate Interval e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and st only one cause on each line. Death /Medical a. Multiple Injuries Imme late Cause (Final disease vamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Discuss or Injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit X AMENDED 4a & 28f, per ME g894 8/24/09 TT #1 as noted cal UNPENDED attending physician or use as the burial The law requires that the death certificate be Physician/Med Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O as been signed be should be deta ð 1 Yes 2 ✔ No 3 Probably 4 Unknown Δ, Completed Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed 1 🗸 Yes No Yes 2 certificate the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ Other<sub>4</sub> Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Jul 29, 2009 After 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Passenger in motor vehicle collision 1900 hrs 1 Natural Yes 2 V No Director: d in by the f Pending death. 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16660 Crabbs Branch Inkirowa Way Derwood, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after 3 Could not be Suicide To the Funeral E determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated Į. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 30, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (A Registrer's Signa State

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			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of ertificate of			giene Reg. No. 200	10 2027
			Decedent's Name (First, Middle, Land)	ast)		711110410 01		2. Date of De	ath	3. Time of Death
	Physici /Medi			Audrey LaRu	e Steele			August	Day Yea 03 200	
	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Dea	ıth	4c. County of D	eath
4			15402 Bramble				lver Sprin			ontgomery
	Funeral Director		219-14-7592	Sex 7. Ag 1□M 2⊠F	e (In yrs. last birthday 84 Yrs.	Months Days			y, Year)	Birthplace (State or Foreign Country) nnsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County		10c, City, Town or L	ocation				10d. Inside City Limits
	the Maryland 28a-f show	ţō	Maryland Montgo	m 0 1637		C.	luor Carin			1 □Yes 2 K No
	r 28a	irec	10e. Street and Number	шету		10f. Zip Code	lver Sprin	ig	10g. Citizen of What	Country?
	eath with	a D	15402 Bramble	wood Drive			20906			U.S.A.
و	72 hours after death with the Maryland natural", or items 23a or 28a-f show licel Examinat must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Armed Forces? 1Yes 2XI	Ever in U.S. 13.	Was Decedent of If Yes, specify Cut		Specify Yes or No rto Rican, etc.)		merican Indian, hite, etc.
-003	72 hours after d "natural", or iten	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's B	If Yes, Give Year or Dates:	16a, Dec	edent's Usual Occu			Specify:  16b. Kind of Busine	White
Maryland 21215-0036	within 72 iene. • than "na t	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	(Give	e kind of work done DO NOT use retire Teache	during most of wo	orking		ducation
٦٩	al Hyg other	BeC	17. Father's Name (First, Middle, Las				1	ame (First, Middle,	Maiden Surname)	
ylag	Menta	2	Charle	es Gehr				Cather	ine Carl	
Mari	2 sho n and Is ma		19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Stree	t and Number or F	Rural Route Numb	er, City or Town, Stat	e, Zip Code)
e,	1 and Health em 27 ther t	-	George William Ste	ele - Husband			··	Silver Sp	ring, Maryla 20c. Location - City	
Baltimore,	Pages nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Disp cemetery, cre George Was	ematory or other pla shington Ce	i	/06/2009	Adelphi, Ma	
Balt	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "na any injury or other traumatic event, It. Man once.		21. Signature of Funeral Service Lee	nsee	H	2. Name and Addr ines-Rinald 1800 New Ha	li Funeral		er Spring, M	Maryland 20904
			23a. Part 1. Enter the Usease, or conshock, or heart follure. List only	plications that caused one cause on each li	the death. Do not en	nter the mode of dy	ing, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death)	a	eatic Cancer a consequence of):					2 1/2 months
	Examiner		Sequentially list conditions	b						
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clause (Ulsease on Injury that initiated events	Due to (or as	a consequence of):					
oʻ	e execu an and rial-tra	Ехаг	that initiated events resulting in death) Last	c Due to (or as	a consequence of);					
68760,	ificate be executed g physician and ts the burial-transit	edical	•	<b>d</b>				·		
	eath cert attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnan ☐ Other <i>(sp</i> ec <i>ify)</i>	су		23d. Date of Month	delivery Day Year
P.	that the	, Phy	Part II. Other significant conditions	contributing to death be	ut not resulting in the i	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ords	w requires that the d been signed by the should be detached	ted by						10	∕es 2 No 3 ∏	Probably 4⊠ Unknown
of Vital Records,	The law r ite has be age 2 sh	Completed			<u> </u>			24a. Was autor perfo	osy prior rmed? death	
ital		BeC	25. Was case referred to medical examiner?				26. Place of De	1 □Yes eath (Check only o		/es 2⊠No
<u>&gt;</u>	S 55	၉	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3 □ DOA Ot	ner: 4 🗆 Nursing	Home 5 ☑ Resid	dence 6 ☐ Other (S	Specify)
	ng Ine	ation:	27. Manner of Death  1   Natural  5   Pending  2   Accident investigatio	28a. Date of Inju (Month, Day	ry 28b. Time of Injury	Wo	ryat rk? ]Yes 2 ∐No	28d. Describe I	now injury occurred	
Division	al or Attending s after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (8 City or Tov		Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier 1	hysician: To the best of miner: On the basis of and manner sta	f examination and/or i	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manne date and place, and o	r as stated. due to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
	D		7		-WI	>	D43202		August 3	3, 2009
			30. Name and address of person who	1	\					2000
	Sta	te.	Charlene Ozanne-Bla 31. Date filed (Month, Day, Year)		, 3305 N. Le ar's Signature —	isure World	Blvd., Si	lver Sprin	g, Maryland	20906
	રાત Registr		MIC 04 2		1. A So	arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #19a 20b 20c perfh 8/6/09 AA County Health Dept lo State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 12:09 PM 2009 Danielle M. Smith 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PANIA SULA REGIONAL HIOMIO 3AUSBURY CLASU CNICAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 🕱 F 26 213-23-1994 Director March 20.1983 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, If a Medical Examiner must be notified at 1 ☐Yes 2X No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1168 St. George Drive 21409 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify: White <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home altimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be Warren W. Smith Laura J. Parker ပ 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 1168 St. George Dr., Annapolis, Maryland 21409 Warren W. Smith Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetary, crematory or other place). Stephens Church Cemetery 8-8-09 Crowsville Maryland 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George P. Kalas Funeral Home 22. Name and Address of Facility 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart genital disease or condition resulting in death) /Medical or as a consequence of) Examiner Falut 06 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe 1 □Yes 2 XNo 1 ☐ Yes 2 No Hospital or Attending Physician: **Director:** After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: 2□No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 63199 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name an STREET SAlisbury VOHRA 100 E. CARROLL 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** рМ 27 2009 July5:41 Frank Schemanski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1615 Ruxton Road Edgewater Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 □ F 2. 1948 Pennsylvania Director 212-54-3208 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2**X** No Directo Maryland Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 1615 Ruxton Road 21037 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married ō 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates:1968-70 White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygienes important: If item 27 Is marked other than any injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) College (1-4or 5+) 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vear **Physician** Herman Edward Schieke, Jr. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 607 Memoria 8. Date of Birth (Month, Day, Jan. 7, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Yea **Funeral** Months 1 X M 2 □ F Days Hours Min. 218-32-0529 72 Jan. 1937 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Maryland Queen Anne's Centreville 1XXVes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 142 Encore Court 21617 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 ☐ No 14. Race - American Indian, 11. Marital Status 1 XXes 2 No
If Yes, Give
Year or Dates: 1959-63 1 Never Married 2 XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 🛪 lo Specify ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event, The angles. Tourism Specialist Tourism 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Edward Schieke Hazel Johnson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn D. Schieke/wife 142 Encore Court Centreville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 7/31/2009 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Lice see 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce tifler

State Registrar 31. Date filed (Month L

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennett So MD , 2195

32. Registrar's Signature

D54488

7-29-2009

Washington St, Easton, MD 21601

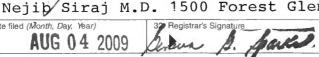
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 25, Day 2009 Year Physician July 2030 Tista Candido Perez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 / 0 4 / 1 9 7 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ☑ M 2 □ F Guatemala 37 none Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Prince George's Hyattsville MD 1 ☐ Yes 2 ☐ XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Guatemala 20783 5904 Knollbrook Drive #100 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 White 3 Widowed 4 Divorced Guatemalan Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ith and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Landscape Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francisca Tista Wenceslao Perez ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Knollbrook Dr.#100 Hyattsville, Md20783 it of Health Arbencito Perez/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. 7/28/2009 Beltsville, Md. 4 Donation 5 ☐ Other (Specify) Funeral Service L PHILIPADS RINALDI FUNERAL SERVICE, P.A trale 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Acquired Immune Deficiency Syndrome **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for es a consecuence of Due to (or as a consequence of) Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ failure to thrive, dysphagia, esophageal 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed candidiasis, electrolyte abnormalities 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 🗆 No 1 ☐ Yes 2 X No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation I Director: And in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) AUG 04 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie



29c. License number

D - 68150

1500 Forest Glen Road Silver Spring, Md 20910

29d. Date signed (Month, Day, Year)

July 27,2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Mary	•	artment of F rtificate of .		-		
			Registrar  1. Decedent's Name (First, Middle, Last)			Bouin	2. Date of De	ath 200	3. Time of Death
В	Physici /Medic		THEODORE AUGUST TIETGE				JULY	30, 2009 Yes	9:15 P <sub>M</sub>
1	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death	1	4c. County of D	
Market			303 FARRAGUT ROAD		ANNAPOL			ANNE ARU	
	Funeral Director		218 28 2666 <sup>1∑M 2□ F</sup>	n yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JUNE 3	o,1932 MA	Birthplace (State or Foreign Country) ARYLAND
	yland now		Usual Residence of Decedent  10a. State	Dc. City, Town or Loc	cation				10d. Inside City Limits
	a-fsl	Director	MARYLAND ANNE ARUNDEL	ANNAPOLIS	5				1 AYes 2 No
	er 28	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	s 23a	eral	303 FARRAGUT ROAD		21401			UNITED STA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, Ital Madical Evertings routh be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Yes, Give		Was Decedent of H fYes, specify Cuba 1 □Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		•
21215-0036	2 hours atural' cal Ex	ted b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Deced	dent's Usual Occup	pation		Specify: WI	
215	ithin 72 ne. <b>nan "n</b>	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12 5+	life. D	DO NOT use retired	during most of wor d)	king		
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Maryland	d be fi	) Be	THEODORE EMIL TIETGE			PAULA	STOLTIN	Maiden Surname)	
ary	should and Men s marke umatic	욘	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street			er, City or Town, Stat	e. Zip Code)
	and 2 ealth a n 27 Is ner trau		NANCY PHILLIPS TIETGE (WIF		'ARRAGUT			MARYLAND	21401
ore	Pages 1 and the nent of He nent of He nent of He nent or other nry or other		20a. Method of Disposition 1 □ Burial 2 🕅 Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	ce)	Date	20c. Location - City	or Town, State
Baltimore,	it. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Specify)		EMATORY		2,2009	EDGEWATER	
Ba	permit. Departr Importa any injt		21. Signature Funeral Service Licensee			ons islan		KALAS FUNE	ERAL HOME R,MD. 21037
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	/Medical Examiner		resulting in death)  Due to (or as a co						
6		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	onsequence of):					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events						
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Box			IF FEMALE: 23c. If yes, outcome of p					23d. Date of	delivery
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ა, შ		by P	Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
ord	w requires t s been signe should be					-	1 🗆 🗅	Yes 2□No 3□	Probably 4 T Unknown
Il Records,	The la ate has page 2	Completed					24a. Was autor perfo 1  Yes	osy prior rmed? death	autopsy findings available to completion of cause of ? 'es 2 □ No
Vital	ician certifi ector	Be	25. Was case referred to medical examiner?  Hospital:		1011	26. Place of Dea	th (Check only o	ne)	
ō	Phy this	<u>۲.</u>	1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 27. Mapner of Death 28a. Date of Injury	2 ER/Outpatient		4 LI Nursing H		dence 6 Other (S	pecify)
DIVISION	Attending r death. ector: After by the funer	cation	1  Natural 5  Pending (Month, Ďay, Ye 2  Accident investigation	ear) Injury	M 1 □	yat k? Yes 2 □No	28d. Describe r	now injury occurred	
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	To the within 2 To the I complet	Σ	29b. Signature and title of certifier	+ > ~ .	29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
		-	20 Name and address of a super who	/ (thom 00-1) 7	Date (			AUGUST 02,	2009
10	CH		30. Name and address of person who completed cause of death	72 Pr66	Print)	(enter	Dr 6	reember	+ MD
	Stat Registra	te ar	31. Date filed (Month, Day, Year) AUG 03 2009 32. Registrar's	Signature	e de l				

	•	For State Registrar	ate of Marylan		irtment of r tificate of			Jiene leg. No. 🦳	000	06076	
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Funeral		Social Security Number     6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day	,	9. Birth	place (State or Foreign	
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Sa-f sl	Director	MD Worcester		_		lin		10 0'''	(141)	Y Yes 2 No	
		10e. Street and Number 9715 Healthway Dri	.ve		10f. Zip Code	21811			en of What Cou USA	intry?	
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permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee	Coller			ess of Facility Th t St., Ca			Home I 21613	P.A.	
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the deat ause on each line.	h. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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aw req is beer 2 shou	Completed						24a. Was a	an	24b. Were au	topsy findings available completion of cause of	
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Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hosp	ital: 1 □ Inpatient 2 □	IED/O-+	t 3□ DOA Ot	hor	th (Check only o				
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DHMH 17 Rev 1/2001

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Registrar

Saltimore, Maryland 21215-0036

of Vital Records,

Division

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Physicia		Registrar 1. Decedent's Nam	e (First, Middle,	Last)							2. D	ate of Death	)au	Year	3. Time of Death	ŀ
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		23a. Part I. Enter	the disease, or	complicat	ions that caus	sed the death	n. Do no	t enter the mode	of dying,	such as ca	rdiac or re	spiratory arre	st, shock,	or heart	Approximate Inte	
Physician		failure. List o	nly one cause	on each li	ine.										Between Onset Death	and
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n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed functual first that the death certificate bas been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	call	<del></del>		٦ <u> </u>												
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V iv	≝	3 🗸 Suicide	6 Cou						, y, ooo	Donairig, et	- 1	or Town 9	State)		rt George G Meade	
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funcar Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit			Certifying P	hysician:	To the best	of my knowle	dge, de	ath occurred at t	the time, d	late and pla	ace, and du	ue to the cau	se(s) and i	manner as	stated.	
To the within 2 To the complet	100	one) 2	/ Medical Exa	miner:O	n the basis of nd manner sta	f examination	and/or i	nvestigation, in	my opinio	n, death oc	curred at t	ne time, date	and place	e, and due t	o trie cause(s)	
To To	Medical	29b. Signature a	nd title of certific		iu ilianilo sta	100.	-	[2	29c. Licen	se number			29d. Da	ite signed	(Month, Day, Year)	
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Regis			106 U4	2009	Len	was	12.	the contraction								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year Month **Physician** 6:42 P.M August 1, Worley Evelyn Cecilia /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Mandrin Chesapeake Hospice House Harwood If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 03/22/1916 5. Social Security Number **Funeral** Months 1 □ M 2 X F 217-36-7714 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If we Medical Exercitive must be recitived at any Injury or other traumatic event, If we Medical Exercitive must be recitived at any Injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🕅 No Funeral Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21401 978 Riversedge Circle Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mvrtle Huston Gordon Collins ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Kingswood Court, Annapolis, MD Donald F. Worley, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Reprioval from State Hillcrest Mem. Garden 08/06/2009 Annapolis, MD 4 Donation 5 Dother (Specify) Rausch Funeral Home, P.A Owines MD 20736 22. Name and Address of Facility Signature of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-each line. Immediate Cause (Final cee cinamo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 2 No Ö 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐Yes 2 ☐ No 2 ZNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Sther (Specify) HOSpule 1 Yes 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Division 1. Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c rtifie D 57028 August 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dru 600 Ridgely Ave. # 231, Annapolis, MD Aditya Chopra, M.D., 31. Date filed (Month, Day, Year) 32. Registra s Signature

DHMH 17 Rev 1/2001

State

Registrar

AUG 03 2009

Division of Vital Rec	To the Hospital or Attending Physician: The law r within 24 hours after death.
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/Medic	al	Jo Anne				1.0	014 7	ul section of Dooth		30 , 20 4c. Count	009	2: 19 a <sup>M</sup>
Examin	er	4a. Facility Name (If no Southern	_			40		or Location of Death Linton				eorge's
Funeral		5. Social Security Number	ber 6. S	ex 7. Ag	e (In yrs. lasi		f Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birth	nplace (State or Foreign
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death	ner	11. Marital Status		12. Was Decedent Armed Forces?		13. Was	s Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No	14. Ra	ace - Amer	rican Indian,
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Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the M	Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f	any injury or other traumatic event, the Medical Examiner must be notified
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2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Eleanor Marian Clark Wiegering  $P^{M}$ 31 2009 3:30 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Asbury Health Care Center Solomons If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 📆 F Director 577-01-1881 96 June 9, 1913 North Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d at 1 ☐ Yes 2 X No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle, Apt. 134 20688 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas George Clark Edna Frances Wells 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Martin Hendricks / Niece 19619 West Huron Lane, Buckeye, AZ 85326 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08/03/2009 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused it. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final milune **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 1/2 been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68750. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. 1 ☐ Yes 2 → Tho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No after death.

Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes SETNO Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0052242 August 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) den J. John Barth, III, MD 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar Signature State

DHMH 17 Rev 1/2001

Registrar

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21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene, ther than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at	à	3 🗆	Widowed	ed 2 X Marrie 4 Divorced 15. Decedent'	s Educati	Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Date on	es? 2 [XNo	16a. D	1 [ ecede	As Decedent Yes, specify ( Yes 2 X Not Usual Ond of work of NOT use re	No ccupa	Specify.		pecify Yes or N Rican, etc.)		14. Rad Bla Specif	ce - Americ ck, White, of y: wh	ite	
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Baltimore.	it. Pages 1 rtment of H rtant: If Ite		1 X 4 □	Donation	Cremation 35 Other (Spe	ecify)	oval from Sta	ate	<ul> <li>b. Place of Di</li> </ul>	sposit cremai en	ion (Name of tory or other Cemet	, olace, ery	,	8/6/	<sup>2009</sup>	20c.		City or To	wn, State	
Ba	perm Depa impo any ii		•	M	eral Service Lic	ac	A.10	D		10	lame and Ad	lia	m S+		Burbage Berlin,	MD	neral	Home	9	
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Divi	ttai or Attendi irs after death al Director: A led in by the f	Certification:	3 🗍 Sı 4 🗍 Hı	omicide	6 Could not determined	201	bullaing, e	etc. (Speci							8f. Location ( City or Tow	m, State)	)			oer,
	To the Hospital or / within 24 hours after To the Funeral Directory completely filled in b	edica	one)		Certifying P Medical Exa	hysician miner: C	To the best on the basis and manner s	of my kno of examina stated.	owledge, dea ation and/or i	th occ	curred at the gation, in my	time, opini	date and ion, death	place, a	nd due to the d at the time,	cause(s) date and	) and mar d place, a	nner as stat nd due to t	ed. the cause(s)	
	<b>6</b> 7 × 4 × 70	Σ	29b. Signa	ture and title	of certifier				•		29c. Licen				,			(Month, Da	_	
	DH 10				of person who		ed cause of	death (Ite	m 23a) (Type	, Print		_					Teuc	3	20	
	Sta Registr	_		ed (Month, L		200	32 Regist	rar's Signa	ature A.	40	uls		6	00 N	orth Wo	Ife S	t, Balt	imore	, MD, 2	1287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Year 15 **Physician** 2009 Moses /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** General HUSPITAL AMBRIDGE DorchesTER orchester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year) Days 247-66-5045 1**X** M 2□ F 1937 South Carelina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylam ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other than the profession of the standing range is a confined at ury or other traumatic event, the Macket Examinar mast as confined at 1 Pres 2 □ No Funeral Director ambr. 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Constructi arpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phel ۵ UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cambridge, MD. 21613 Street Mozella 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 8109 Cambridge, MD. 4 ☐ Donation 5 ☐ Other (Specify) CeMetery 22. Name and Address of Facility Henry P. 21. Signature of Funeral Service Licensee 5 10 washington 23a. Party Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** metastatic concer els disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 ☐ Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ t es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → No 24a. Was an autopsy performe 2 NO 2000 1 ∏Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 5 ☐ Pending investigation Natural 2 Accident 1 □Yes 2 □No hours after death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 108 H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rosa Mateo, 503 Byrn Street, Cambridge, MD 21613 Dr.

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $J_{u}^{MQnth}$  28, 2009Ye ar **Physician** 10:50 a M Billy Joe Whitlock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month Day, May 25, 9. Birthplace (State or Foreign 6. Sex If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1932 South Carolina 1 ▼ M 2 □ F 419-40-8735 77 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 🏋 No Funeral Director Stevensville Oueen Annes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event. The Market and 1000 once. 21666 United States 412 Bay City Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Hes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. Completed by Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Labor Westinghouse Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Lewis James B. Whitlock မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevensville, MD 412 Bay City Road Iva June Whitlock/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1√Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Departion 5 ☐ Other (Specify) Mount Rose Cemetery July31,2009 Glade Spring, VA 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Sign we of Funeral Arvice Licensee 12 Ridgely Avenue Annapolis, MD 21401 23a. art . Enter the . Is ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart frilly. List only one cause on each line.

Immedia: Cause (Fir all disease) recondition resulting in death)

a. Congestive Heart Failure Approximate Interval Between Onset and Death weeks Due to (or as a consequence of): weeks Myocardial Infarction Sequentially list conditions Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Stage Renal Disease months Due to (or as a consequence of): Pseudomembranous Colitis weeks Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯◯No 24a. Was an Intermittent Atrial fibrillation autopsy performed? Peripheral Vascular Disease 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 XXVI Certification: To

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Funeral** 

Director

28a-f shov

sician and burial-transit physician the burial attending p been signed by the should be detached certificate ha director, After this funeral death. neral Director: A

Division of Vital Records, P.O. Box 68760,

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XX npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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within 24 hours a

To the Funeral C

completely filled

Medical

31. Date filed (Month, Day, Year) State Registrar

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32. Registrar's Signature

2001

30. Name and address of person who empleted cause of death (Item 23a) (Type, Print

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 1:00 pM 02 2009 August Myung Sook Yu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours Days 1 □ M 2 🖾 F Months South Korea August 10, 1935 73 Director 505-92-3654 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Midical Exercitor count be notified at 1 ☐ Yes 2K No Director Bethesda Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a U.S.A. 20817 10524 Westlake Drive, #304 Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify Specify: ð 3 Nidowed 4 Divorced Asian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Homes 3 Caretaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kan Lan Lee Hak Sung Pyun ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9608 Falls Bridge Lane, Potomac, Maryland 20854 Kun Sung Yu - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any injury or ot
once. 1 ☐ Burial, 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 08/10/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartifallyre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) aftending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Year Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Esophageal Tumor page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 2 🗆 No 1 ☐Yes 2 🖾 No 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending I after death. 1 🛚 Natural 5 Pending investigation after death. 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title ٩ August 3, 2009 D59980 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad

DHMH 17 Rev 1/2001

State

Registrar

Sandra M.

31. Date filed (Month, Day, Year)

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95/00 2009

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6430 Rockledge Drive, Suite 510, Bethesda, Maryland 20817

M.D.,

3. Registrar's Signature

Delistathis,

AUG 04 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 14, Day 2009 **Physician** Aug.2:20 Efthemia Alevrogiannis /Medical 4a. Facility Name (If not institution, give street end number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3411 Cornwall Rd. Baltimore Dundalk 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) July 16, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 1 □ M 2 🗹 F Hours Year) Months 213-04-9489 65 Director Greece Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov ral", or items 23a or 28a-f shores and Examiliate relations. Md. Baltimore Director Dundalk 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or a limportant: if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, its Moulcal Examilian must be an once. 3411 Cornwall Rd. 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify. Specify: Greek Completed by 3 ☐ Widowed 4 Z Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 yrs. home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be llnknown Atsidis Unknown P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nick Alevrogiannis 3411 Cornwall Rd. Dundalk Md. son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug Pite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Connelly Funeral Home Of 1110 Sollers Point Rd. 21 21. Signature of F ral Service License 23a. Part Lenter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** 10 uears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been si Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1□Yes 2□No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 5 A Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled it To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Name and address

31. Date filed (Month, Day, Year)

AUG

9 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Rose Z. Aaron 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 07:10 A M **AUGUST** 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 2614 WILLOW GLEN DRIVE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-27-1912 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 215-03-1506 MD 97 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or other traumatic event, Ir. Medical Exercity. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No **Funeral Director** BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2614 WILLOW GLEN DRIVE 21209 12. Was Decedent Ever in U.S. Armed Forcas? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: WHITE Be Completed by 3 Midowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARCO SALES & SERVICE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JACOB** ZIMMERMAN LEAH STEIN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10029 THE MENDING WALL, COLUMBIA, MD 21044 CHARLES AARON/SON 20b. Place of Disposition (Name of AN SHE EMUNA) 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages 1
Department of F.
Important: If iten
any Injury or ott 1 Burial 2 Cremation 3 Removal from State 08-16-2009 | BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) AITZ CHAIM 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee Skett Mur 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician OROnan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner physician and s the burial-trans Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Records, Viital Division of within 24 hours a

To the Funeral C

completely filled

Maryland 21215-0036

Baltimore,

State Registrar

cal

29a. Certifier (Check only one)

AUG

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

W Be wedne Are# 504 Bolo 21 41

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iurew Leianu B	1·	- For State Certificat	te of Death	Reg. N	No. 20026	3,8
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Da August 13, 20	Vear	
ledical Examir		Andrew Le1and Brown  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	$\dashv$
		Shady Grove Adventist Hospital	Rockville		Montgomery	_
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	lay) If Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9. Birthplace (State or For Country)	reign
Director		216-85-4653 1XM 2_F	Yrs. 1 4	July 9,	2009 Maryland	_
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h with	uneral	11. Marital Status  1 XXNever Married 2 Married 2 Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Jamie Lee Brown	Daniel:		- new management - comment - comment	
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death with the Maryland  nt of Health and Mental Hygiene.  nt: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print) Danielle M. Brown / Mother  19b.	Mailing Address (Street and Number or 1944 Canvas Back Way	y, Damasc	us, MD 20872	
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Baltimore, permit. Pages I at Department of Her Important: If ite		21. Signature of Foneral Service Licensee 11.00387	22. Name and Address of Facility Rapp Funeral and	Cremation	Services	ļ
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To th withir To th compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)	
	_	661111	O.C.M.E.		August 14, 2009	
		30. Name and address of person who completed cause of death (Item 23a)				
		Zabiullah Ali, M.D. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD	21201 		
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To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical		ysician: To the best niner: On the basis o and manner sta	f examination ar							
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		leadh		N	B	04	-14-06	•	Aug	13	+2004
10		30. Name and address of person who o	completed cause of d	eath (Item 23a)	(Type_Print)	NOR	TH CHAR	LESS	STREE	T_	all
10	\	21 Date filed (March Day Van)					TH CHAR BALTIK	MORE	MD	212	<i>uy</i>
S Regis	State strar	31. Date filed (Month, Day, Year)	E.	ar's Signature	par	Las					
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ August 17, Elizabeth Nora Brokaw 2009 5:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Hours FEB 15 Mary Land T985 Director 213-11-6177 24 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Laure1 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 8800 Deep Water Lane 20723 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married 3 Widowed 4 Divorced ☐ Yes 2 X No Completed by If Yes, Give 1 ☐ Yes 2 👿 No Specify: Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Student Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Frederick Brokaw. III Nancy т. Wendell W. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick W. Brokaw, III, father 8800 Deep Water Lane Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Metro Crematory, Inc. 08/17/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition nculinon week ( Medical resulting in death) Due o (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of,: if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending

signed by the attending physician and be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be After this certificate has within 24 hours after deatl To the Funeral Director Hospital 24 hours a

page 2

filled in by the funeral director,

Medical

Accident

Suicide

31. Date filed (Month, Day, Year)

AUG

4 Homicide

Investigation

determined

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6 Could not be

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Meral Hygiene. Important: If item 27 is ma Meral Hygiene. Important: If item 27 is and Meral early in than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signate 29c. License numbe 29d. Date signed (Month, Day, Year)

work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number.

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16,2009 4:15p M August C. Barrett, Jr. James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Northwest Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1**X** M 2□ F Months Days Hours 212-28-1476 80 7-31-1929 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 □Yes 2 No Director Pikesville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. Funeral 504 Sudbrook Lane 12. Was Decedent Ever in U.S Armed Forces? 1953 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Types 2 No 195.

If yes, Give 1951 – Year or Dates 1951 – 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗙 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Electronics Industry is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be С. Barrett, Sr. Katherine L. Cockey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other tra. Pikesville, Maryland 21208 Patricia Wellbrock Sister 7610 Seven Mile Lane 20b. Place of Disposition (Name of Department, regulatory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State □ Donation 5 □ Other (Specify) 8-19-2009 Pikesville Cemetery of Furtheral Covice Covisee 21. Sig dura 22. Name and Address of Facility Ruck Towson Funeral Home Inc. Towson, Maryland 1050 York Road ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Physician Cardiovascular Disease 4 therescierotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (up as a our bequerior of): Examine law requires that the death certificate be executed Due to (or as a consequence of): burialphysician s the burial Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Hospital or Attending Physician; The certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hosping...
within 24 hours after death.
To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MSKCYCHDAMIMD 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200, Keisterstown 25 Main St., Suite N.S. Pajapakse. MID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AU /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Season's Hospice 9. Birthplace (State or Foreign Country)
Poland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1**X**M 2□ F Months Days 220-50-4075 11/08/1920 Director 88 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examirer must be notified at PA Delaware Lansdowne 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 34 Pennock Terrace 7 PCode 0 Great Britian Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Completed by iit. Pages 1 and 2 should be filed within 72 mountain. Pages 1 and 2 should be filed within 72 mountain. 3 ₩Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grocery College (1-4or 5+) Grocer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tomas Chmielewski Felicia Petrosky ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau Wendy Chmielewski/Daughter 34 Pennock Terrace Lansdowne, PA 19050 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 17, Aug. 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Owings\_Mills, MD Har Sinai Cem. 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee MOIYYZ 8717 Green Pastures Dr. Balto, MD 21286 23a. Part1. Elver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner and burial-trai Due to (or as a consequence of) Physician/Medical the attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 Yes 2 No 3 Probably Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? /es 2 1 ☐ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗽 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To MOSPICE funeral 28a. Date of Injury (Monthy Day, Year) 27. Manner of Veath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 2 Accident 5 Pending A NI 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu r death.

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

31. Date filed (Mont)

29b. Signature and title of certifier

ASCOL

and address of person who completed cause of death (Item 23a) (Type, Print)

34 Registrar's Signat

1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death lugust Day Month Year **Physician** 1300 M 200 MOTA /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Season da (Ayrs. last birthday) Jan 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Security Number Age Funeral Year Days Hours 114-48-2493 128M 2□ F 95 10 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Funeral Director low son Jai 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number .ل. 04 MOOK 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status 1 Never Married 2 ☐ Married 1 Tes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black <u>م</u> permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exagnes. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Healthcare 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be John ೨ Janna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) brother hurnton onkers 10704 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FUMERIAL ugh and Por HeCullah palto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ance disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cut.

Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760€ resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) P.O. 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑Other (Specify, 1 Tes 2 M No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

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DHMH 17 Rev 1/2001

Registrar

		For State	State of Ma	aryland / Dep	artment of t ertificate of			63.6	200	26201		
		Registrar  1. Decedent's Name (First, Middle, Las	t)		Tuncate of	Dealli	2. Date of Dea	Reg. No.	000	3. Time of Death	_	
Physici		Lawrence		Cai	nes		Month	Day.	2009	5:07 PM	J	
/Medic		4a. Facility Name (If not institution, give				or Location of Death	0.5		nty of Death	5 0 1 1	-	
LAGIIIII		Union Memoria	al Hospi			Lmore	NA					
Funeral Director		5. Social Security Number 6. Sex 224 − 52 − 5546 ★★ 2□ F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		h v, Year) -30	9. Birthplace (State or Foreign Country) Unk.			
'natural', or items 23a or 28a-f show Affeal Examiner mast be nutflied at		Usual Residence of Decedent  10a. State 10b. County	-	10c. City, Town or L	ocation				10	0d. Inside City Limits	;	
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	Director	10e. Street and Number	ber 10f. Zip Code					10g. Citizen of What Country?				
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Agrantone res	by Funeral	11. Marital Status Unk.  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 【AZI If Yes, Give Year or Dates:	1 ⊟Yes XXNo If Yes, Give		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes ※N No Specify:		s or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White				
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	Daniel Carnes-Brother   207 North Luzerne Avenue Ba										_	
ď		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Location - City or Town, State   20c.										
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	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery  Month Day Year						
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in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined						il Route Number,				
completely filled	edical C	29a. Certifier  (Check only one)  (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	ĕ	29b. Signature and title of certifier	Λ	~	29c. Licen	nse number		29d. Date sig	gned (Month,	Dav. Year)	-	

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EZINMA ACHEBE ND 201 E. UNIVESITY BANCWAY BALTMOR, MD ZIZIS 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29c. License number AT 2438946 A2

08,15,2009

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 3:00 A Dorothy Read Corbin August 15, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 310 Harlan Street Bel Air If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🛣 F 83 Director 30, 1926 Maryland 217-20-9261 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County show 'Y is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating the rectilled at 1 Yes 2 □ No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 310 Harlan St. Funeral 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r. Elementary/Secondary (0-12) College (1-4or 5+) 12 Program Analyst U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ James Robinson Preston ဨ Edna (nmn) Standiford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:s Department of Health a Important: If item 27 is any Injury or other trau Robin Corbin Little/ Daughter 907 Chesney Lane, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-19-09 Friends Cemetery Fallston, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. Service Licens 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ancs cance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter ordering g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit physician and s the burial-trans Due to (or as a consequence of): Box 68760, certificate be Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a d be detached for □Yes 2□No Ö 9 Unknown <u>a</u>: 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performed 1 ☐ Yes 2 XNo 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: after death.

I Director: After do in by the funers Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after e Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00058475 PHYSZUZAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHELZPNJLAT ARR MO JEN ATMOSO RD 60 2 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Day **Physician** Crouse Pau1 Henry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Towson Ruxton Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 ☑ M 2 ☐ F July 21, 1925 Maryland 84 Director 215-24-5995 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1∩a State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 U.S.A. 5 Caraway Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itel 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Balto. County Schools Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Addie Pearl Naylor ၀ William Shroyer Crouse, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once. Sparks, MD 21152 Mary Jane Tegeler Sister 15920 Falls Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 8/17/09 Hampstead, Maryland 22. Name and Address of Facility 11824 Reisterstown Road 21136 ELINE FUNERAL HOME Reisterstown, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Foot disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed iabetes Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) q | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 🗌 Yes 20 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐Yes 27 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and add who completed cause of death Bellong Lome #216, Towson 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

AUG

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ Arnold F. Caneva 2009  $A^{M}$ 2:21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 1 ∰ M 2 ☐ F Birthpiac , Country) PA Funeral Davs Hours 224-14-9997 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3403 Yardley Drive 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 🗆 Widowed 4 🗀 Divorced White Year or Dates. WWII injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Biologica Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Laboratories 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Caneva Alice Luger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmella Caneva - Wife 3403 Yardley Drive, Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-17-09 Baltimore, MD Bayview Crematory 21. Signature of Funeral Service Lie Bradley-Ashton FUneral Home 2134 Willow Spring Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 🗌 No the Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autonsy 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred s after death. 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tonnowi, MD 15109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

10000011

555 W

32. Registrar's Signature

1ch nawy 40

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Gertrude Cappollonia 6:05p 2009 August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genesis Elder Care Dundalk Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 2-12-1920 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🛛 F Months 89 216-09-1853 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Dundalk 1 □ Yes 2 X No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7232 German Hill Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 X Never Married 2 ☐ Married 1 □Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Factory worker 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Cappoloni Rosa D'Emelia 19a. Informant's Name/Relationship (Type. Print) nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Rallo 102 Whip Lane, Glen Burnie, Maryland 21060 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/2009|Baltimore,Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr.FH 21. Signature of Funeral Service Licensee ~ Le Conkling St., Baltimore, MD 21224 23a. Part 1. Enter the discher shock, or hear ailure. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause ( disease or condition resulting in death) CIEROTIL CARDIOVASCULAR DISEASE

**Physician** /Medical Examiner

> burial-tran and

as attending

physician s the burial

signed by the a

page 2 should

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

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Completed

Be

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Exami

Physician/Medical

2

Be Completed

Certification: To

Medical

29b. Signature

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

72 hours after

d 2 should be filed within the and Mental Hygiene.
7 Is marked other than "r

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked, any injury or other traumatic evone.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death  4 ☐ Pregnant at time of death  9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

23d. Date of delivery

Day

Year

Month

		TLIYes ZINO ILIYES ZINO						
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1	(Month, Ďay, Year) Injury Work?  M 1 □ Yes 2 □ No	d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number City or Town, State)						

4 Homicide	determined	building, etc. (Specify)	City or Town, State)
29a. Certifier (Check only one)		cian: To the best of my knowledge, death occurred at the time, date and placer: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	

29d. Date signed (Month, Day, Year)

Dundale MD 21222 2 market Place 31. Date filed (Month, Day, Year)

State Registrar

within 24 hours after death, within 24 hours after death.

To the Funeral Director: After this completely filled in heart.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06359 State of Maryland / Department of Health and Mental Hygiene Otis Conway 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 13, 2009 2151 hrs Otis Medical Examiner Conva 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 1628 Delano Court 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min 61 Director eb.16 Country) Maryan 1 M 2 F 52-524 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 No s 23a or 28a-f show e notified at once. rmit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Iteath and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Count 10f. Zip Code 10e. Street and Number Delano Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 Never Married Yes 2 No specify Yes, Give Year 4 Divorced Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Schoo MD 21215-0036 12 17. Father's Name (First, Middle, Last) 1) oswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ophelia Carte, 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State - Fores arrison Donation 5 Other Specify: 22. Name and Address of 21. Signature of Funeral Feyrice Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of: If any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical attending physician a for use as the burial - 1 AMENDED UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 V Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available Be this

Division of Vital Records, P.O. Box 68760, After To the Funeral

Compl					performed?	death? 1 ✓ Yes 2 No				
	25. Was case referred to medical		26.Place of Death (Check only one)  spital: 1							
o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2								
tion: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?  1 Yes 2 No	28d. Describe how inju	ry occurred				
Certification	2 Accident Investigat 3 Suicide 6 Could not determine	t be 28e. Place of Injury - At	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, or Town, State)				
Medical C	292 Certifier and due to the equación and manner as stated									
š	29b. Signature and title of certifier			29c. License number	29d. [	Date signed (Month, Day, Year)				
	his his.	NC)		O.C.M.E.	August 14, 2009					
	30. Name and address of person who Ling Li, MD Assistant N			altimore, MD 21201						

Registra

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 16, 2009 ear Physician/ 11:05 Donna Μ. Carpenter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours NOV. 7 1 949 1 □ M 2 🔽 F Missouri Director 348-42-3932 59 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Maryland Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13800 East Devonfield Drive 21013 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 No If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Sollege (1-4 or 5+) St. Paul's Lutheran Ch Secretary permit. Page 1 and 2 should be filet.
Department of Health and Mental Hv.
Important: If then 27 is meany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Manetz Patricia Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carpenter / Husband 13800 East Devonfield Drive Baldwin, Md. 21013 Monte L. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp:8/18/09 Towson, Maryland 4 Donation 22. Name and Address of Facility Signature of Furier 5 Srvice L 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and each line. Approximate Interval Between Onset and Death Immediate Cause (Final Reso Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Zuneral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2∕ ∑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 Ø No Donna Yes 2. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 I ER/Outpatient 3 I DOA Other (Spec Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at 1 Natural (Month, Day, Year) dimenter, 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: T. the best of my knowledge, deeth d'et the time, dete end place, and due to the causels) and manner as state

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

score Honou 31. Date find (Month, Day, Year)

AUG 1 9 2009

Honrawing

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

arka

555w tarsontown Bl Vd

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23a PtII per dr. 2896, 10/07/09dhb.

State of Maryland Department of Feath, and Mental Hygiene

Amend Items 25,27,28a-f per me, 2896, 10/02/09dhb

Reg. No. 1 1 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** BRYANT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Medical Center BALT MORE BAH MORE

If Under 1 Year | If Under 24 Hrs. |
Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**√** M 2□ F Days 215-28-9865 Director 76 April 1, 1933 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, the "Actival Exeminarian and Plant 2008. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ¥Yes 2 □ No Director Maryland Baltimore City Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 124 W. Franklin Street Apt. 1306 21202 Funeral United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No1954If Yes, Give
Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Completed by 1 □Yes 2 🙀 No Specify White Specify: 3 ☐ Widowed 4 ☐ Divorced 1956 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Transportation Taxi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Joseph Davenport Anna Μ. Bryan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 492 St. Barbara Lane, Odenton, Maryland 21113 Garry Davenport/Son August 13 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TULMONAR! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Subarachnoid Hemorrhage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Subdural Hematoma 24a. Was an autopsy performed? Yes 2 1 No 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Extural 5 ☐ Pending investigation Subject ejected driver of scooter struck a curb 2 Accident
3 Suicide 1 ☐ Yes 2 X No 07/16/2009 3:32p. Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Jack and Hanover filled in by within 24 hours after or To the Funeral Direct determined 4 ☐ Homicide Roadway Streets, Baltimore, MD 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMANTHA GREENC Street BALL MORE, MD 2120 Wood IDNOETH MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day AUG Ρ 8 2009 WILLIAM WALTER DANSIE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 6/26/1911 9. Birthplace (State or Foreign Country) 5. Social Securify Number 7. Age (In yrs. last birthday) Months Days Hours Min. MA 98 263-24-5322 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 20814 10e. Street and Number 8003 Kentbury Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. orces: 2 NoWII 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: White Specify If Yes, Give Year or Dates: 3K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Navy Elementary/Secondary (0-12) College,(1-4or 5+) Civil engineer 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Thomas Dansie Caroline Grist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8003 Kentbury Dr. Bethesda, MD 20814 William G. Dansie, son 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Chesapeake Crematory 8/18/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitRapp Funeral & Cremation Svcs, MO1539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery Year

**Physician** /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

the

death with

MD

Director

Funeral

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Be

Examiner

Physician/Medical

9

Completed

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Certification: To

Medical

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Medical Examinar must be notified at

2 should be filed within 72 hours after c n and Mental Hygiene. Is marked other than "natural", or iten

and 2 should

Health sem 27 i

permit. Pages 1 and Department of Heal Important; If item any injury or othe once.

Baltimore, Maryland 21215-0036

Box 68760.

<u>P</u>

Division of Vital Records.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Underson Injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

Month

23e. Did tobacco use contribute to the cause of death?

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed

28d. Describe how injury occurred

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 🖾 No

25. Was case referred to medical examiner?

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

32. Registrar's Signature

2 🗌 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 🔀 No 27. Manner of Death 1 Natural
2 Accident

□Yes 2□No

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

1 Tes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

3 Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and

29c. License number D-62654

29d. Date signed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Pi Line b per MD G894 8/19/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 315 A M 2000 RICHARD WILLIAM DUGAN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner tranklin Square BUHMORE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. **T** M 2 □ F **Director** 218**-7**8-5415 50 26, 1958 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Foxwell Road 21085 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Security Guard</u> Security Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Donald Dugan Rose Marie Markiewicz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Foxwell Road, Joppatowne, MD 21085 Richard D. Dugan / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 8-13-09 Towson, Maryland 21. Signatury of Funeral Service Lic 22. Name and Address of Facility McComas Funeral Home, P.A. othleen 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) failure **Physician** /Medical Due to (or as a consequence of): **Examiner** Cirrhosis Sequentially list conditions, if any series to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of: Examiner To the Hospital or Attending Physician: The law equires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient P 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10063327 DUIZON H. WOLDETHINDT

DHMH 17 Rev 1/2001

State

Registrar

9000 FRIANKLIN SO DR BAHIMOTE, MD 21237 Dr. Gizaw Wolden I WOT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2009

31. Date filed (Month, Day, Year)

2. Registrar's Signature

Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4a. Facility Name (If not institu ion, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Randallstown Season Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F 76 Director Mar 16, 1933 227-38-8022 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Madical Examinar must be notified at Director Reisterstown MD Baltimore Co. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21136 items 23a Funeral 4828 Pleasant Grove Rd 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ∏Yes 2 ⊋ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🛣 No þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Housewife own home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Floyd Webster Valley Plaugher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 903 Academy Ave, Owings Mills, MD John S. Donovan Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Carroll Cremation 8/17/09 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facility Reisterstown, MD Eline Funeral Home 11824 Reisterstown Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
arely filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. | ☐Yes 2☐No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 24a. Was an certificate has hirector, page 2 s autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation Year) 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 0 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Nes Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) npleted cause of death (Item 23a) (Type, Print) ORIGINAL

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐Yes 2 X No

VA

Black, White, etc.

white

USA

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who con

Year)

AUG

31. Date filed (Month, Day,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan					and M	ental Hy	giene			
			Registrar	Looth		Cel	rtificate	OTL	Jeath		2. Date of Dea	Reg. No.	200	3. Time 4	of Death
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See St.	/Medic		Joan Dent  4a. Facility Name (If not institution	. give street and no	umber)		4b. City, T	own, or	Location o	f Death	August		009 ounty of Dea	6:45	AM
	Examin	ег	Bay Ridge Hea				Anna						nne Ar		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year		24 Hrs. Min.	8. Date of Birt	h	9. Bir	thplace (State ountry)	
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altimore, Maryland 21	ir health and Mental Hyg item 27 is marked other other traumatic event, t		19a. Informant's Name/Relations			19b. Mailir	ng Address (	Street a	and Numbe	er or Rura	l Route Numbe	er, City or	Town, State,	Zip Code)	
and 2	Health (		Bay Ridge Hea	lthcare			Van Bu		Stre		Annapo	lis,	MD 2	1403	
ore	O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	n State	Place of Dispo cemetery, crei	sition (Name matory or oth	e of her place	e)	D	ate	20c. Loca	ation - City or	r Town, State	
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Die			shock, or heart failure. List Immediat ause (Final	only one cause on	each line	lol	5.60	CAS	/2/	10,0	r m	Stere	Tina)	Interval B	etween
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oertific	attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, o	utcome pf pregn	ancy						23	d. Date of de	elivery	
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ding.	After funera	ion	Natural 5 ☐ Pendin	g (Mo	onth, Day Year)	Injury	M 20	Bc. Injury Work	ໃດ Yes 2∐i		edd. Describe i	low injury	occurred		
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בי פון בי בי	l Dire	Certification:	4 ☐ Homicide determ	buit	ding, etc. (Speci	fy)					City or Tov	vn, State)			
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			111001	VE 96	use of death (Iter	N Bu	REN	5	( , ,	KNI	IMPGL	16	MD	214	03
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month Maurice E. Duncan **Physician** 14, 11:35 A<sup>M</sup> August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye Feb 6, 1 Casey House Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 X M 2 □ F 004-24-1437 81 Maine Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show 2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene is marked other than "natural", or items 23a or 28a-1 show its marked other than "natural", or items 23a or 28a-1 show its marked other than "natural", or items 23a or 28a-1 show its marked to a show it will be not than the notified as the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3524 Chiswick Court USA by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No 1946
If Yes, Give
Year or Dates: 1949 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Businessman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event Be Milton Duncan Amv Patterson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3524 Chiswick Court Silver Spring, Maryland 20906 Flora M. Duncan, Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 08/15/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septicemia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Examine use as the burial-trans and resulting in death) Last Due to (or as a consequence of): physician pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? ģ Month Year 5 Other (specify) signed by the a d be detached for □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Advanced Dementia Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed this certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$  Other (Specify) Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 1 Tes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated.

10x

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

of Vital Records,

Division

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

J. Koud

AUG 19 2009

29d. Date signed (Month, Day, Year)

August 15, 2009

32. Registrar's Signature

29c. License number

0 63743

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year August **Physician** 2:14 AM 2009 16 Elizabeth Drovillard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 D 219-28-5312 76 May 18,1933 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 TYes 2 TriNo Director Parkville Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 2106 Townhill Road Apt. B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify White ģ If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 12 years ages 1 and 2 should be filed vent of Health and Mental Hygis It: If item 27 is marked other y or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Smokler Daniel Smokler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 2106 Townhill Road, Apt. B. Parkville, Md. 21234 Vivian Dreves August 19 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important; If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, 7110 Sollers Point Road, Dundalk, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ischemic Bowel, Immediate Cause (Final disease or condition resulting in death) Bowel **Physician** /Medical Due to (or as a consequence of): Examiner 48 hours Septic Shock Sequentially list conditions, if any, reading to hinterball cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 1 week the death certificate be executed burial-transit Urosepsis Due to (or as a consequence of): attending physician for use as the buria 8 years peripheral Vascular Disense Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋛ 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 within 2. 29d. Date signed (Month, Day, Year)

State Registrar

Elena Forochar, 31. Date filed (Month, Day, Year)

AUG 19 2009

29b. Signature and title of certifier

Union Memorial Hospital, 210 East 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

24

38946

UNIVO

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav 14, August 2009 6:25 A Ruth Riggin Everd 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 1 □ M 2 🖾 F Months Days Hours 91 Apr. 4, 1918 Maryland 212-09-9724 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Maryland Bel Air Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3016 Goat Hill Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2█No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Walker Keller Mary Francis Steelberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joanne R. Debelius / Daughter Glenray Ct., New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdn. 8-19-09 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Dulmonary ita/ disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Euro to for as a nunsequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUSPIL 1 Yes 2 No

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, It's Medical Exyminat must be notified.

Saltimore, Maryland 21215-0036

y physician and as the burial-trans as attending | ф þ signed to

page 2 s has certificate this After this funeral c

Division of Vital Records, P.O. Box 68760, Hospital or Attending n 24 hours after death.

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O State 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles SI CHARVES MO 701 AARON 31. Date filed (Month, 32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Registrar

RHENT KNOWN AS LINDA MARIE FLAHERTY Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

	1 - State Registrar	ne (First, Middle, L	no.tl		Cei	rtificate of	Death	2. Date of Dea	Reg. No.	. 0 0 0	3. Time of Do
an			AHERTY					Month August	Day	Year 2009	16 30
al er	4a. Facility Name		ive street and numb			-	r Location of Dea	-	4c. Cou	inty of Death	
	Singi Hospital of Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)					BALTIM If Under 1 Year	· <b>&gt;</b>		lone	-1 (0)	
	5. Social Security 219-56-43 Usual Residence of	342	1 M 2 XX	. Age (In yrs. la	Yrs.	Months Days	If Under 24 Hrs Hours Min		1949	Cou	place (State or i intry) y I and
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ecto	Maryland Baltimore Baltimore								(1111 1 0	1 □ Yes 2	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 894 8-19-09 yr State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homes Cockeysville 15el fi more MASONIC If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2√2 F 265-26-0297 1922 North Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertial Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2▼ No Director Cockeysville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21030 **USA** 300 International Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Elementary Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie Davis Nelson Catherine Sneed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9291 Broken Timber Way Columbia, Maryland 21045 Thomas R. Fulcher, Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State <del>-09</del>/15/09 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George E Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Ress 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): DAYS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an as cular 1) useuse 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIBERTU 300 Fritan

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 4 Fisher Margaret 2009 tug ust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Baltimore Certan If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 M 2 V Months Days Hours Min. 2/5-/4-956 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 Nes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No \$ Specify: SIACK 3 ₩idowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usp retired) Elementary/Secondary (0-12) College (1-4or 5+) SEMDL. Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, If once. 17. Father's Name (First, Middle, Last) 18., Mother's Name (First, Middle, Maiden Surname, Be Pages 1 and 2 should be 1 ment of Health and Mental ဥ Informant's Name/Prelationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Downson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee caused the death. Do not enter each line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on node of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed Were autopsy findings available prior to completion of cause of death? autopsy certificate performe 2 KNo 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hugust 15 2009 19650 30. Name and address of person who completed couse of death (Item 23a) (Type, Print) S Anderson 30 BALL More 22 South Greene St 21201

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear 14, 6:20 A 2009 Merva June Filler August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Madonna Heritage Jarrettsville Harford Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months 1 □ M 2 🕱 F 82 234-38-9827 June 18, 1927 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 X No Maryland Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2443 Bailey Road 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2√2 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Milligan Dye Sr. Ruth Estella Whitford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2443 Bailey Road, Forest Hill, MD 21050 Melvin Filler / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-19-09 Timonium, Maryland Dulaney Valley Mem. 4 Donation 5 Other (Specify) of Funeyal Service Lice 22. Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Rd., Abingdon, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stag disease or condition resulting in death) ears Due to (or as a consequence of) Parkinson ean Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

with

death

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be ပ

Department of Health and Mental Hygiene. Important: if item 22 are 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "defical Examina must be notified at once.

signed by the attending physician and I be detached for use as the burial-transit Physician/Medical þ icate has been si , page 2 should b Completed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be

Examiner Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 410 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Assured Livi 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

isal Honore

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 - Homicide

1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

21206

D 31295

8/14/09

245

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701 Kenwood X ( oesz

31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa Cer	rtment of Health and N 719709dhb tificate of Death	/lental Hyg R	iene	261.13
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Deat Month	Day Year	3. Time of Death
America	/Medic		Keith Bennett Goodman	the City of Death	August	17, 2009 4c. County of Death	6:45 A.M
	Examin	er	4a. Facility Name (If not institution, give street and number)  33 Daria Court	4b. City, Town, or Location of Death Tinonium		Baltimore	
46	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, July 22	9. Birth Cou 1935 Harr	place (State or Foreign ntry), 1SDUNG, PA.
	Director		171-28-1167 /4 Yrs.  Usual Residence of Decedent		bury 22		
	rylanc how	L	10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits 1 □Yes 2本No
	8a-f s	Director	Maryland Baltimore County Timonium			0.00	
	a or 2		10e. Street and Number	10f. Zíp Code 21093	'	Og. Citizen of What Cou United St	_
	ns 23	Funeral	33 Daria Court  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri	ican Indian,
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Everther must be profilled at	by	1 Nover Married 20 Married 1 Dies 2 No DO2CE	f Yes, specify Cuban, Mexican, Puerto □Yes 2 No Specify:	Hican, etc.)	Black, White,	etc. White
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Maryland	S as S		(,	g Address (Street and Number or Ru		r, City or Town, State, Zi 1, Maryland	
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	Physician /Medical Examiner	6 7	23a. Part 1 inter the disease, or complications that cause the death. Do not enter shork or learl failure. List only one cause on each line.  Immedia Cause (Final disease or condition resulting in death)  Due ty (or as a consequence of):  Sequentially list conditions,	er the mode of dying, such as cardiac	or respiratory arr	est,	Approximate (perva) Between onset and Death
0.	ecuted and I-transit	Examiner	that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
38760,	icate be executed physician and the burial-transit	dical E	d				
.O. Box 6	Physician: The law requires that the death certificate has been signed by the attending rt director, page 2 should be detached for use as	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
rds, P.	quires that in signed build be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	3
Vital Records,	ian: The law requir rtificate has been s tor, page 2 should	Completed				sy prior to o med? death?	topsy findings available completion of cause of
<b>X</b> it	sician: certific irector,	o Be	25. Was case referred medical examiner?  1 ☐ Yes 2 10 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Dea		ence 6 ☐ Other (Spec	zifu)
	g Physical dispersal dis	<b>-</b>	27. Manny of Death 28a. Date of Injury 28b. Time of	<del></del>		ow injury occurred	-ny)
sior	Attending or death. ector: After by the funer	atio	2 Accident investigation	M 1 □Yes 2 □No			
Division	F 9 E C	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (S City or Tow	Street and Number or Ru n, State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dirth completely filled in	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and or in and manner stated.	vestigation, in my opinion, death occur	e, and due to the durred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
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	19+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Hector Silva, M.D. 7505 Osles Drive	Print) Towson, Maryl	and 21	204	
ì	Sta Registi		31. Date filed (Month, Day, Year) 18 20032. Registrar's Signature	of area			

# megon Maryland 21215-0036

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed

Be ၉

Exami

Physician/Medical

Completed by

Be

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IF FEMALE:

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. M. M. dical Examination in the notified at once.

**Physician** /Medical Examiner

that the death certificate be executed attending physician and for use as the burial-tran Box 68760 signed by the a P.0. Records,

al or Attending Physician: The law requires is after death.
I Director: After this certificate has been signad in by the funeral director, page 2 should be red in by the funeral director, page 2 should be red in by the funeral director. Division of Vital

Division	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	Medical Certification:
	Sta Registr	
DHI	MH 17 Rev 1/2	001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Edward 09 1:15A Gregory August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NA Baltimore Future Care Irvington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-13-28 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 € M 2 □ F 216-20-5599 81 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location XX Yes 2 No Na Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code W. LaFayette Avenue 21216 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etcAfrican 1 Never Married 2 Married 1 □ Yes XXNo Specify: Specify: American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Housing Authority Unk. NA Landscape 18. Mother's Name (First, Middle, Maiden Surname) Unk. 17. Father's Name (First, Middle, Last) Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121619a. Informant's Name/Relationship (Type. Print) Edythe Gregory-Wife West LaFayette Avenue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Pk. 08-22-09 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Arbutus, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 040 Stale Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Datę signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MID 2000

001

M' Eulaw St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMEI

31. Date filed (Month, Day, Year)

AUG

821

32 Registrar's Signature

# Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or Baltimore, Maryland 21215-0036 permit. Pages Department of Important: If it any injury or o

**Physician** 

Examiner

**Funeral** 

Director

23a or 28a-f show

Funeral Director

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "Medical Eventher must be notified at

the Maryland

/Medical

NONE

MD

VA

10a. State

Box 68760. P.O. Division of Vital Records.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Thomas Goffaux 11:40 Aug 17, 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard Elkridge 6672 Deep Run Pkwy Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Days Hours Months MD Feb 25, 2009 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Elkridge Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 6672 Deep Run Pkwy 21075 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James D. Goffaux Kathleen Williston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Goffaux Father 6672 Deep Run Pkwy Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 19, 2009 4 Donation 5 Other (Specify) Atlantic Crematory, LLC Glen Burnie, MD ure of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 + Moiaga Approximate Interval Between Onset and Death 23a. Part 1 Soft r the diviase, or complications that cause 4 he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall re. List only one cause on each line. Immediate Cause (Final ZELLWER 5.4NDROME disease or condition resulting in death) Due to (or as a consequence of): GASTRO ESO, SEVERE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CONGESTIVE resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? OZDE 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1∐Yes 2 No 26. Place of Death (Check only one) Other: 4 🗀 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician After this neral Director: A within 24 hours after death.

To the Funeral Director: A

**Physician** 

/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VENTRI WLAD 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Teath 1 ■ Natural 2 □ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my kpt 2 Medical Examiner: On the basis of examiner and manner stated. 29a. Certifier wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of cert

MARREDITSVILLE

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FIELD

32. Registrar's Signature

STRAT

31. Date filed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17perFH, G894, 8/19709, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month 20:35 **Physician** August 2009 ynn /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore stu Hospita Trenera Date of Birth (Month, Day, 3-13 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign yrs. last birthday, **Funeral** Min. 1 □ M 2 1 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be rollifed at 1 os 2 □ No Funeral Director MD timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2120 Ilvania 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 Black 1 □Yes 2 No Specify: ģ Specify 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry Department of Health and Mental Hygiene important: If item 27 is marked other than 'natur any hijury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kace oncession 18. Mother's Name (First, Middle, Majden Father's Name (First, Middle, Last) Be ည 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Apt. 1D. Balto., mD 21201 Hard 904 tennsylvania Awe, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Baltimore, mo Zion Compassion Funeral Services Javoke Terrell, P.A. -121 S. Stricker Street Balto., MD 21223 re of Funeral Service Licensee Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** P515 /Medical Due to (or s a consequence of): Examiner Kesistant Drug Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed mmunodel Division of Vital Records, P.O. Box 68760, 🕣 sician and burial-trans Due to (or as a consequence of) certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | € No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 R. DEVINOTA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DevKota Mary 19nd 0 Treneral 32 Red 31. Date filed (Month, Day, Year) State Registrar

MICHELL

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HARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 4:29 PM Holden 2009 Ollie Augus 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMOVE NA ALTHORIE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 09-05-22 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 86 Yrs. 5. Social Security Number 1 ☐ M 2 🗓 F Months 215-22-7278 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Baltimore NA Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 USA 10 North Glen Road 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Jewelry Store Custodial Engineer Na 8th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk. Scott Eleanor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3406 Washington Avenue Baltimore, MD 21207 Alhajji-Shassan Abdullah 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ Removal from State 08-20-09 Zion Cem. Lansdowne, MD 4 □ Donation 5 □ Other (Specify) Wy ie uneral Home .A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 Mull 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Unlong one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Leur A CUTE MYOCARDIAL INPARCTION Due to (or as a consequence of): Zcyears CORONNAY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown CHRONIC REMAL FAILLIRE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an CEREBRAL VASLULAR ACCIDENT autopsy performed? Yes 2 100 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 | Inpatient 2 | ER/Outpatient 3 | DoA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 do 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

be executed requires that the Division of Vital Records, To the Hospital or Attending Physician: within 24 hours are.

To the Funeral Director: Aft

State

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

permit. Pages 1 and 2 sho ld be filed within Department of Health and Mental Hygiene. Important: If item 27 is nerked other than "any injury or other traun stice event, the Mental Industrial Control of the Industrial Control of the Industrial Control of the Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Industrial Control of Indust

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After this certificate funeral director, pag

page

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,-Year)



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15 HEYWIT 2009

**Physician** /Medical Examiner Physician/Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

Director

Funeral

Completed by

Be

r than "natural", or items 23a or 28a-f shov the Medical Evantiner must be notified at

other

. Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 Is marked oth

other

Department of Heal Important: If item 2 any Injury or other once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Be Completed by

Certification: To

Medical

1 Yes 2 No

5 Pending investigation

6 □Could not be

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Thomicide

29b. Signature and title

ending physician and use as the burlal-transit

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as

State Registrar

108 2

28a. Date of Injury (Month, Day, Year)

and manner stated.

29c. License number Do062634

1 ☐Yes 2 ☐ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) AUGUST 18, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HICKORY MATEEN RIDGE RO COLUMBIA MO

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 19 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OSSIE BEATRICE HUTCHINS 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner itizens Nursina Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 M 2 K 96 Director 218-74-7536 Oct. 14, 1912 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 □Yes 2 No Director Maryland | Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 7 must be n death with 2317 Edwards Lane 21015 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If them 27 is marked other them. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 'natural", or items dical Examiner me 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. þ 3⊠ Widowed 4 Divorced White Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၀ Felix Monroe Edwards Stella Jane Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul A. Hutchins / Son 326 Montgomery Dr., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 8-21-09 Bel Air, Maryland Air Memorial Gdn 21. Signature of Funeral Service Licenses 22. Name and Address of Facility

McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. 23a, Part1. ducase Immediate Cause (Final disease or condition resulting in death) an 0000 Physician /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier Willian D32600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) evolution St. Hanre De Goace

State Registrar

Kammiden

31. Date filed (Month, Day,

Millian MD

32. Begistrar's Signature

1106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19a Per INF G895 9/10/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUGUST 12:52FM 2009 Sarah R. Hasson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Center Towson Joseph Medical Saint If Under 1 Year If Under 24 Hrs.\_ 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Oct 15, Maryland 94 Director 216-20-0614 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "widted Examinar", with be notified at 1 ☐ Yes 2 🖾 No Perryville Ceci1 Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21903 425 Otsego Street; Box 37 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2KINo Specify þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) cosmotology beautician permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygit Important: If item 27 is marked other 1 any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Sarah Estella Mahan Thomas Wilbur Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 474 Five Farm Lane; Timonium, Maryland 21093 Gail #. Carney/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street 21. Signature of Funeral Service Licenser Roll 11 d S . Wa director Baltimore, Maryland 21201 23a, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line. Immediate cuse (Final disease or contition resulting in dea 30 MINS **Physician** ARRHYTHMIA CARDIAC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) □Yes 2 No ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown PERIPHERAL VASCULAR DISEASE nis certificate has been si director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D39215 30. Name and address of person who completed cause death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MD 21204 7601 CHNNINGHAM M.D 31. Date filed (Month, Day, Year)

State Registra

DHMH 17 Rev 1/2001

Jarko

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For Stata Ragistrar	State of	Maryland		artment of tificate of		Mental Hy	giene Rag. No.	9 26421
			Decedent's Name (First, Middle, Last	st)					2. Date of De Month	Day Ye	3. Time of Death
	Physicia /Medic	al .		muller-		1g			August	16, 2009	12:39 a M
	Examin	er	4a. Fecility Name (If not institution, give					or Location of Dea	itn	Baltimo	
H	Funeral		719 Maiden Choic	ex 7	. Age (In yrs. I	ast birthday)	If Under 1 Yea			th 9.	Birthplace (State or Foreign Country)
	Director		216-03-8094	□M 2√ΩF	97	Yrs.	Months Day	Hours Mir	April 1	1, 1912 M	aryland
	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	Į.	Maryland Baltimo	nre		Cato	nsville				1 ☐ Yes 2√∑ No
	r 28a	irec	10e. Street and Number	)LC		oacoi	10f. Zip Code			10g. Citizen of Wha	t Country?
	23a o 23a o 151 by	Funeral Directo	719 Maiden Choice					1228		United St	
	tems	nue	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	Btack, V	American Indian, White, etc.
5	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	**		1⊡Yes 2DXN	Specify:		Specify: V	Mhite
o-0030	filed within 72 hours after death with the Maryland Hygiene. Hygiene. The Western Saa or 28a-f show ent, tre Medical Evantination in the ricities and		15. Decedent's E. (Specify only highest gra	ducation		(Give	dent's Usual Occ	e during most of w	rorking	16b. Kind of Busin	ess/Industry
V	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use reti.	red)		Orm Hon	20
7	iiled w Hygier ther ti nt, In		12 17. Father's Name (First, Middle, Last	)		HOM	emaker	18. Mother's N	ame (First, Middle	Own Hon , Maiden Surname)	ie
yland	id be i ental l ked o ic sve	To Be	Chester K. Chane					Lou	ise Gebl	hardt	
Mary	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The marked other than "neturel", or items 23a or 28a-f show other traumatic svent, the Modical Evaning mest be notified at	-	19a. Informant's Name/Relationship (			19b. Maili	ng Address (Stre			er, City or Town, Sta	ite, Zip Code)
χ. Σ	and 2 lealth a m 27 is		Patricia A. Heirmulle	er/Daughte	20h B		Thackery	Avenue,	Catonsv	ille, MD 2	
saltimore,	ges 1 It of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		tate	emetery, cre	matory or other p	Aug	gust 18,		
	permit. Pages of Department of Himportant: If ite any injury or of 2005.		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice				ematory,				, <u>Maryland</u> f Maryland,Inc
g	Department any is		Sula Sol	L	a neasi						ryland 21228
ď		-	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the deat						Approximate Interval Between Onset and Death
ı	Physician		Immediate Cause (Final disease or condition			erebro	vascular	Disease			Years
	/Medical Examiner		resulting in death)		r as a conseq						
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C.							
/60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (d	or as a conseq	uence of):					
	death certificate be executed e attending physician and of for use as the burial-transit	dlcal		d							
RG X	leath certifical attending phy I for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						23d. Date of	of delivery
XON.	death e atter	icla	in the past 12 months?		nth 2 □ Feta unt at time of d		□Ectopic pregna □ Other (s <i>pecify)</i>			Month	Day Year
J.	at the de 1 by the a stached i	Phys	9 Unknown					Tues in Dort I	23a Did	tobacco use contribu	ute to the cause of death?
Š,	law requires that the as been signed by th 2 should be detache	рý	Part II. Other significant conditions	contributing to de	atti but not res	alting in the t	indenying cause	given in Fait i.			☐ Probably 4 ☐Unknown
Records,	w requir been si should	Completed							24a. Wa	s an 24b. We	re autopsy findings available
Ř	o − 0	ошо							- auto	ormed? dea	or to completion of cause of th? ] Yes 2 ☐ No
of Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of D	Death (Check only		
<u>&gt;</u>		To E	examiner? 1 Yes 2 No	1			III 30 00A			sidence 6 Other	
	ling P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		f Injury n, <i>Day Year)</i>	28b. Time o Injury		ljury at Vork? ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Division	Attending Physician: r death. ector: After this certifici by the funeral director,	ficat	2 Accident investigation 3 Suicide 6 Could not lead to determine	e 28e. Place	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location	(Street and Number own, State)	or Rural Route Number,
á	Dir	Certification:	4 Homicide	buildir	ig, etc. (Specit	ry)			City of 70	JWII, 3(216)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in In	edical (	(Check only 2 Medical Exa	miner: On the ba	sis of examina	owledge, dea ation and/or in	th occurred at the	time, date and play y opinion, death o	ace, and due to the courred at the time	e cause(s) and mann e, date and place, and	er as stated. d due to the cause(s)
	To the h within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and mann	er stated.			ense number		29d. Date signed (	
	£ <b>₹</b> 8		+ 100VX+	10	MD		D4	7009		August 18	3 2009
1	1.1		30. Name and address of person who				, Print)				, 400
	( V		Phillip Stone, M.	.D. 711	Maiden gistrar's Signa	Choice	e Ln, Ba	ltimore ]	Maryland	21228	
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 9 20			1. La	alle				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26422 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 200°9" 10:35 PM Dimitric Herzberger Francis August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Care Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Maryland Month, Day, Xear November 26 1 🕅 M 2 □ F Months Days Hours Min 65 **Director** 218-42-3618 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Pikesville Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 U.S.A. 7112 Deerfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technical Trainer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Madeline DaRosa Kenneth Eugene Herzberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 7112 Deerfield Foad, Pikesville, Maryland Joan Herzberger / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Removal from State 4 Donation 5 Other (Specify) Carnison Forest. 8-24-2009 Cwings Mills, MD 21. Signature of Veral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. ancer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death Other (specify) the 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed bage 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

AUG 1

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Henrawi MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Henrani, UD. 555 W. Howsontown Blvd, Towson MD 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06418 State of Maryland / Department of Health and Mental Hygiene Jeremy Willard Henry Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 16, 2009 1126 hrs Medical Examiner Jeremy W. Henry c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Parsonsburg 7495 Madeline Circle 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Mary land **Funeral** Months Days Hours Feb 28, 1983 Director 1 XM 2 F 26 216-04-4891 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Parsonsburg Wicomico or items 23a or 28a-f show must be notified at once. Md. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21849 7495 Madeline Circle 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No White Specify Yes 2 X No specify: Give Year Divorced of Health and Mental Hygiene.
If item 27 is marked other than "natural", of the traumatic event, the Medical Examiner. 3 Widowed 4 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Baltimore, MD 21215-0036 Framer 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kauffman Jill Fred Henry Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 217 White Water Loop Conway, SC 29526 Ms. Jill Henry/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) t: If it 1 Burial 2 X Cremation 3 Removal from State Towson, Md. 8-19-09 Important: injury or oth Hilltop Service Co Donation 5 Other Specify: 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of uneral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Heroin, tramadol and oxycodone intoxication and Approximate Interval Physician Between Onset and Death /Medical Immediate Cause (Final disease cocaine use а aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, reading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and hysician/Medical AMENDED 23a,27,28a-f,perME, g894 8/31/09 TT X UNPENDED physician the burial the Hospital or Attending Physician: The law requires that the death certificate be 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 signed by the attending be detached for use as 1 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ᄑ Yes 2 No 3 Probably 4 ✔ Unknown þ Completed 24b. Were autopsy findings available certificate has been s ector, page 2 should 1 24a Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No ~ Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital director, Be Other<sub>4</sub> examiner? Residence 6 Other: Scene Hospital: Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 After this 1 V Yes ۵ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury funeral 27. Manner of Death Certification: unk Yes 2 X No Natural Pendina within 24 hours after death To the Funeral Director: Fd 8/16/09 Fd 11:10 am the 2 Investigation Accident 28f. Location (Street and Number of Rural Boute Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 6 X Could not be or Town, State) 7495 M Parsonsburg, MD 3 Suicide house 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 17, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year AUG 1 9 egistrar's Signature State 2009 Registra

DHMH 17 Rev 1/2001 OCME 2006

1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** Aug 11 2009 Jackson 001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Naryland Medical Center Saltimore 8. Date of Birth (Month, Day, Year) may 1 1957 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕇 F Months 587-08-4752 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: if item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a "ledical Exacitar must be notified at once. Director Md. Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1400 Hadwick Dr. Apt.D 21221 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ∏No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doctors Office Medical Secretary 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sharon Kelley Wilder Davis Tuttle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 1400 Hadwick Dr. Apt. D Balto., Md. 21221 Clarence E. Jackson Jr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery Aug. 19, 2009 Crownsville, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hwy. Balto. Md. 21225 namurellski 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Herniation **Physician** Drain /Medical Due to (or as a consequence of): **Examiner** Massive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) P.0. 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

and manner stated.

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Ohio

29d. Date signed (Month, Day, Year)

St. Bultimore, MD

10d. Inside City Limits

1 ☐ Yes 2 ▼ No

amend #7 per State 68 War 9 Jahr 1/09 ep Entment of Health and Mental Hygiene

State Registrar

Medical

29a, Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG

11.

1 9 2009

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

09-063	71		

ease Type or Print in Black Indelible Ink. Easure Al/Gepies Are Legible. State of Maryland / Department of Health and Mental Hygiene	
State of Maryland / Department of Health and Mental Hygiene	
Ctate of Maryana / Department	

bert Anthony		- For State	of Maryland / Departmet Certificat	nt of Health te of Death	i and Menta		2 ( eg. No.	009 2642
Physicia	an/	1. Decedent's Name (First, Middle,Last				2. Date of Dear	Day Year	3. Time of Death 0942 hrs
edical Exami		Delbert Anthony  4a. Facility Name (if not institution, give		4b. City, To	wn, or Location of [	August 14	4c. County of	Death
		2428 Harriet Avenue		Baltimo			N	<i>[</i> 49
Funeral Director		5. Social Security Number 6. Sec. 551-92-24117	1	day) If Under Months Yrs.	1 Year If Under 2 Days Hours	Min. Julia		9. Birthplace (State or Foreign
>	ļ	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or	r Location			7	10d. Inside City Limits
ath with the Maryland items 23a or 28a-f show any ast be notified at once.	tor	MD NI	A PA	TIMORE	5		0g. Citizen of Wha	1 Yes 2 No
e Mary or 28a- fied at	Funeral Director	10e. Street and Number	15 T A15	10f. Zip C	112717		11.9	A
with th	ral	11. Marital Status		13. Was Deceden	t of Hispanic Origin	? ( Specify Yes or No	14. Race - White,	American Indian, Black,
r death or iten	nu	1 Never Married 2 X Married	Armed Forces? 1 Yes 2 No		Cuban, Mexican, F	ruento Rican, etc.)	4	Place
s after rral",	þ	Widowed 4 Divorced     Decedent's Education (Specify on	If Yes, Give Year or Dates: 11v highest grade completed) 16a, D		No specify: Occupation (Give kir	nd of work done	Specify: 16b. Kind of Busi	ness/Industry
21215-0036 Uld holis filed within 72 hours after death with the Maryland Menla Hygiene marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	uring most of work	ing life. DO NOT us	se retired)	Homo	- DESOT
5-0036 lled within 7 Hygiene. I other than	om	17. Father's Name (First, Middle, Last)	- WIA 100	7	18,Mother's	Name (First, Middle,	Maiden Surnatne)	
21215-003 buld be filed withi Mental Hygiene, marked other the	Be	DE IDERT	Jack SON		Tor.	OTNY	DECK	
MD 21 d 2 should tth and Me n 27 is ma	٢	19a. Informant's Name/Relationship (T	ype, Print ) 19b.	Mailing Address	Street and Numb	er or Rural Route Nu	mber, City or Town	177, 21231)
alth 2		20a. Method of Disposition		Disposition (Nam ry or other place)	e of cemetery,	Date	20c. Location - 0	City or Town, State
imore Pages 1 ment of H tant: If i		Burial 2 Cremation 3 Donation 5 Other Specify	Removal from State	Seal-Fort	25/	9-21-09	Owno	9 Mills MM
at mit. part por		21. Signature of Funeral Service Licen	see /	22. Name and	Address of Facility	270 Fr	PAUTAN A	299 PALTIONSVAN
		23a. Part . E der the disease, or comp	lications that caused the death. Do not	enter the mode of	f dying, such as car	diac or respiratory ar	rest, shock, or hear	t Approxim e Interval
Physician /Medical		fail re List only one cause on ea	ach line. Atherosclerotic Cardiovascula	,				Between Onset and Death
kaminer			Due to (or as a consequence of):					
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
	Examiner	(Disease or injury that initiated c.						201
cuted md transit		events resulting in death) East	Due to (or as a consequence of):				·	
exe ian a	edical	UNPENDED	AMENDED #1 per ME	g894 8/1	9/09 TT			
68760, certificate be oding physics as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	Fetal death	3 Ectopic	pregnancy	23d. Date of o	delivery Day Year
OX 6876( eath certificate attending physe	sician/M	past 12 months?	4 Pregnant at time of death 5					
BOX (he death or y the attent by the attent hed for use	Phys	Part II. Other significant conditions	g Unknown  contributing to death but not resulting	in the underlying	cause given in Par	t I. 23e. Did	tobacco use contri	oute to the cause of death?
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physomphetely filled in by the funeral director, page 2 should be detached for use as the b	þ	rattii. Other significant conditions	Continuating to death but not resenting	, in and anadarying			es 2 🗸 No 3	Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require als after dealh all pircotor. After this certificate has been si led in by the funeral director, page 2 should be	Completed					24a. Wa	s an 24b. V	Vere autopsy findings available rior to completion of cause of
eco he law ate has	dwc					per		eath? Yes 2 No
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?			26.Place of Death (		_	
f Vit Physic or this c	10 E	1 ✓ Yes 2 No 27. Manner of Death			OA Other:	Nursing Home 5	Residence 6 ve	
ion of tending Ph eath tor: After the funeral	ion:	1 Natural 5 Pending	(Month, Day, Year)	Time of many	1 Yes 2			
ivision or Atteno after death Director:	Certification:	2 Accident Investigat 3 Suicide 6 Could not	28e Place of Injury - At home, fa	arm, street, factory	, office building, etc	28f. Location or Town		er or Rural Route Number, City
Div spital o ours af neral D	Certi	4 Homicide determine	ed (Specify)					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physic one) 2 Medical Examine	cian: To the best of my knowledge, dear: On the basis of examination and/or in	ath occurred at the nvestigation, in my	time, date and pla opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.		c. License number			ed (Month, Day, Year)
		D_M.	- M		O.C.M.E.		August 15,	2009
		30. Name and address of person who		144 D-+::	Street Dolling	oro MD 24204		
,		Donna M. Vincenti, MD	Assistant Medical Examiner  32 Registrar's Signature	111 Penn	Street, Baltimo	ле, IVID 21201		
§	tate	31. Date filed (Month, Day, Year)	ozan togistidi o olgilatalo	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Physician/ 10015 Medical or Location of Death 4c. County of Death Examiner ty. Town. ltimore 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours В Director items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director altimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Gilrar Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Black, White, ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or 20b. Place of Disposition (Name of 20a. Method of Disposition Burlal 2 Cremation 3 Removal from State cemetery, crematory or other pla 4 Donation 5 Other (Specify) oings Mills Signature of Funeral Se ce Licensee NO155 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Complications of disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No g Unknown 9 Unknown eral Director: After this certificate has been signed by ifilled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Vision of Vital examiner? 2 X No ပ္ Hospoci 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury death. 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) (3) 49194 RNP st 17,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Grant North Charles St Baltimor, MD 31. Date filed (Month, Day, Year) 32. State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 10.56 Rudolph KOVOCS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dear 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster Birthplace (State or Foreign Country)
 OH 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 18, 7. Age (In yrs. last birthday) **Funeral** M 2□F Days Hours 270-10-2926 94 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "hadical Examinar must be notified at Director 1 □Yes 2□No OH Cuyahoga Parma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10000 W. Ridgewood Drive Apt. 512 44130 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify: White 3 V Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Manufacturing <u>Machinest</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kovacs Mary (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 Is
any Injury or other trau Mr. John Kovacs (Son) 7110 Gaither Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation: 8/18/2009 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one was entered to each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HTRIAL CHRONIC FIBRILLATION /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical tension Der IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?/ 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director; 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DRI **1**54339 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V MEMORIAL AVE. WESTMINSTER, MD 21157 MAHBOOB ASHRAF 1D 200 32 Registrar's Signatur 31. Date filed (Month, Day, Year) State **AUG 19** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar	State of Maryla		artment of H rtificate of L		a Mer		ene g. No.			
Decedent's Name (First, Middle, Last,				2. Date of Death Month Day Yea			3. Time of Death			
Mildred ELizabet					, 200g		8:20 AM M			
4a. Facility Name (If not institution, give	4b. City, Town, or	4b. City, Town, or Location of Death			4c. County of Death					
4749 Homesdale A	Baltimore			Baltim		timore				
Social Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. S	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			8. Date of Birth (Month, Day, Year)  Jan 17, 1924 Ma		9. Birthp	ace (State or Foreign			
217-12-8/58	M 2⊠F 85	Yrs.			Ja	an 17,	1924	Mary]	and	
Usual Residence of Decedent  10a. State 10b. County	10c C	ity. Town or Lo	ocation					11	Od. tnside City Limits	
MD Baltimo		ltimore							1X∑Yes 2 □ No	
	Le Da	TCIMOIC					) - Oitings	1 Mallo an Causa		
10e. Street and Number	10f. Zip Code 21206				10g. Citizen of What Country?					
	4749 Homesdale Avenue				2 (04	Van as Na	USA - 14. Race - American Indian,			
11. Marital Status	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	uerto Ric	an, etc.)	Black, White, etc.					
1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 🚰 No tf Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No			Specify: white				
	16a Doco	16a. Decedent's Usual Occupation					16h Kind of Rusinges/Industry 1171			
15. Decedent's Edu (Specify only highest grad	(Give	kind of work done of DO NOT use retired		16b. Kind of Business/Industry unk						
Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		ice	,						
17. Father's Name (First, Middle, Last)						ne (First, Middle, Maiden Sumame)				
			1							
Harry George Krame  19a. Informant's Name/Relationship (T)	no Address /Street	Marie Winter  Address (Street and Number or Rural Route Number, City or Town, State					Code)			
Robert W. Keenan/			Roxbury Co				-		-300/	
20a. Method of Disposition			osition (Name of	, ,	Date		20c. Location		wn State	
1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4X Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cres	matory or other place	(a)			LOC. LOCATION		, ciaio	
21. Signature of Euneral Service Licens RONALO S.	Wade Directo		State Ana Baltimore	-	-		. Balı	timore	Street	
23a. Part1. Enter the disease, or como shock, or heart failure. List only o	lications that caused the de	ath. Do not ent	ter the mode of dyin	g, such as car	rdiac or re	espiratory arre	est,		Approximate Interval Between	
Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):  Due to (or as a consequence of):									Oliset and Death	
that initiated events resulting in death) Last	Due to (or as a conse	equence of);								
tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	□Ectopic pregnancy □ Other (specify) _					23d. Date of delivery Month Day Year				
Part II. Other significant conditions co	underlying cause giv	.,,			Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown					
1 yes 22(No 3   F								JUFIOL		
GUA) INSU				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autoprior to co death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes		psy tindings available mpletion of cause of 2 No				
25. Was case reterred to medicat				26. Place of	t Death (0	Check only on				
examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth				nce 6 🗆 C	Other (Specif	ý)	
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	of 28c. Injur Wor		28d. Describe how injury occurred		1-1				
3 Suicide 6 Could not be determined	home, farm, st	reet, factory, office	281	281. Location (Street and Number or Rural Route Number, City or Town, State)						
	vsician: To the best of my k iner: On the basis of exami and manner stated.									
29b. Signature and title of certifier	29c. Licens	29c. License number			29d. Date signed (Month, Day, Year) August 11 2007					
30. Name and address of person who company who shall be supported by the same and address of person who company who shall be supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and address of person who company which is a supported by the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same	ompleted cause of death (It	em 23a) (Type,	Print) Venue Be	v Aswa	re 1	Maryla	xd, 21:	210		

State Registrar

Physician /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Depertment of Health and Mental Plygiene. Important; if Item 27 is marked other than "natural", or Items 23a or 28s-1 show eny Injury or other traumatic event, the Mudical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physicien: The law requires that the death certilicate be executed within 24 hours after death.

To the Funeral Director: Atter this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) AUG 19 2009 32. Registrar's Signature parked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 17, 2009 **Physician** Rose Juli Lawson 6:20 aM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel | Months | Days | Hours | Min. | 8. Date of Birth | Months | Days | Hours | Min. | 0 3/31/1924 Birthplace (State or Foreign WV Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D 234-70-7676 85 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notifled at 1 ☐ Yes 2 No Director MD Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20770 9J Southway Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes > No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental H Be Rosa (Unknown) Andrew Bolash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9J Southway Rd. Greenbelt, MD 20770 19a. Informant's Name/Relationship (Type. Print) Hubert Lawson, son of Health Item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1:
Department of He
Important: if Iten
any in|ury or oth 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/18/2009 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. MO1539 Signature of Funeral Service 933 Gist Ave. Silver Spring, MD 20910 n 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Liter course, if Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transit Atrial Fibrillation and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy P Month Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Urinary Tract Infection 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2√ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Opatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 1 2 Natural 28b. Time of 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After d in by the funera After Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitai within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Buc 08/17/2009 D0059649

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 19 2009



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ikechukwu Mbonu, MD; 9501 Old Annapolis Rd. #302; Ellicott City, MD 21042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per th 8094 8-31-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MATTA 5:30AM FREDERICK 2009 /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK CITIZENS CARE AND REHAB If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 373-34-2212 1 M 2□F Days HICKIGIA N <del>68</del> 78 Director Pelo 7 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h Counts 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f sho
 or other traumatic event, Item Calical Examiner must be notified at FREDERICK FREDERICK 1 ☑Yes 2 ☐ No MD Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21701 798 AVE MOTTOR 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Iffres, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION College (1-4or 5+) Elementary/Secondary (0-12) CIVIL ENGINEER 4 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY & BECKROW MATA MIKE ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10298 PLACID PLACE NEW MARKET MD Department of Health a Important: If item 27 is any injury or other trainonce. (DAU) CHRISTINA RENSHAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 mints Bues Cron. Aug 14, 2009 5 mints Burs 22. Name and Address of Facility ARY L. ROLLING FUND HOME 21. Signature of Funeral Service Licensee Tolo NO WEST SOUTH ST PREDERICK MED 21701 Kuy X. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancer 1 Tes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No this certificate 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 422 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D0055061 August 14, 2009 Mo 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar AUBRIE

31. Date filed (Month, Day, Year)

NA64

AUG 1 9 2009

MD

32

Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

300 West Ninh St; Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sandra McCuske	1	- For State	State c	of Maryland		tment of ificate of		id Ment		n No			
Physicia	_	Registrar  1. Decedent's Name (First Middle Last) 2. Date of Death							h	3. Time of Death			
Medical Exami	ner	Sandra	McCu						Month August 13		0700 hrs		
		Facility Name (if not institution, give street and number)     Harbor Hospital					4b. City, Town, or Location of Death  Baltimore				4c. County of Death		
Funeral		5. Social Security Number	er 6. Sex	7. Ac	je (in yrs. las	st birthday)	If Under 1 Yea	ar If Under	24Hrs. 8. Date of Bir		Birthplace (State or Foreign		
Director		219-90-0848 1 Months 2 F 35 Yrs. Months Days Hours Min. August 29 1973 Delaware											
su s	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									10d. Inside City Limits		
r death with the Maryland or items 23a or 28a-f show any must be notified at once.		Md. Aı	nne Aru	ndel							1 Yes 2 X No		
Aaryla Aaryla 128a-f	ecto	10e. Street and Number					10f. Zip Code		1	0g. Citizen of What Co	ountry?		
Sa or	١	580 Terrace	e View .				21225			U.S.A.			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Marital Status     Never Married	2 X Married	12. Was Deceden Armed Forces	?				in? ( Specify Yes or No Puerto Rican, etc.)	- 14. Race - Am White, etc.	erican Indian, Black,		
i", or i	Ī	1 Yes 2 X No  3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify:						Specify: Wh	ite				
ours af	d b	15. Decedent's Educati		pecify only highest grade completed)			's Usual Occupa	ation (Give k	ind of work done	16b. Kind of Busines	s/Industry		
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withir spiene.	E O	12th Homemaker  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)					s Name (First, Middle, I	Own Home					
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212 ould b d Men s marl	2	19a. Informant's Name/F				_	,		ber or Rural Route Nur	•	ate, Zip Code)		
MD nd 2 sh alth an m 27 i		Robert McCu		Husband	Look D		errace V		ve. Balto.	Md. 21225	or Town State		
Ore, eslar of Hea If ite	Ì	20a. Method of Disposition 1 X Burial 2 C	_	Removal from S	tate CI	rematory or oth	er place)						
time t. Pag tment rtant:		4 Donation 5 (		7	HOI		S Cemete		8/18/09	Balto. M			
Bal permi Depar Impo injur		21. Signature of Funeral	2	med	M	, 7			Gonce Fund	eral Servi	ce P.A.		
Physician	$\dashv$	23a. Part I. Enter the dis	ease, or compli	cations that cause	d the death.	Do not enter th	e mode of dying	g, such as ca	y Balto I ardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and		
/Medical xaminer		Immediate Cause (Final disease a. Pulmonary thromboembolism Death											
\anninei		or condition resulting in	death)	oue to (or as a con:	sequence of	):							
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
Q	mim	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):											
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876( ifficate ng phy as the b	M/u	IF FEMALE: 23b. Was decedent pregi	nant in the	23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day  Ye.							,		
ox 6 or the cert	sician//	past 12 months?  1 Yes 2 No 9	■ Upknown		at time of dea	. 41	ner (Specify)						
the death c the atten by the atten	اڃ			unknown  S contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			
Records, P.O. Box 6876  The law requires that the death certifical cate has been signed by the attending phage 2 should be detached for use as the	ā			orbid ob				g	1Ye	s 2 No 3 F	Probably 4 🗸 Unknown		
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		25. Was case referred to	medical				26.Pla	ce of Death	(Check only one)	2_1.0	100 2 10		
Vital   hysician: this certif	o Be	examiner? 1 ✓ Yes 2	No H	ospital: 1 Inpat	ient 2 🗸	ER/Outpatient	3 DOA	Other <sub>4</sub>	Nursing Home 5	Residence 6 O	ther:		
ion of tending Pheath.	T:T	27 Magner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred											
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Division of Vital Records, pital or Attending Physician: The law require ours after death.  Beral Director: After this certificate has been sifilted in by the funeral director, page 2 should be	rtifi	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Ci or Town, State)									Rural Route Number, City		
Hospi 24 hou Funer rely fil	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	Σ	29b. Signature and title	of certifier	11 21	)			nse number		August 13, 20			
3		Mr. Grasilf mo											
en bero		30. Name/and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
St Regis	ate trar	31. Date filed (Month, Da	9 2000	32. Regist	rar's Signatu	re do a	1						
DHMH 17 Rev 1/2		00117		1	8.	ORIGINA	L						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 8894 8/19/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 255 PM **Physician** 09 MITCHE CDONALD /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NIA MANOR Wast BRIDGE If Under If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 M 2 □ F Hours 213-58-4219 5 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21228 526 USA 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Black 'natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiene. Department of Health and Mential Hygiene, important: If Item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name 18. Mother's Name (First, Middle, Maiden Surname) Middle, Last. Pages 1 and 2 should be 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nitche atonsville, mo 21228 52 William Dr. King 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Funeral Gervie Lin 21. Signaturu 23a. Patri. Enjer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lung Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University in Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a burial P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 🔲 Ectopic pregnancy Year Month 5 Other (specify) ed by the a □Yes 2□No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2.1 No this certificate 1 ☐ Yes 2 ZNo 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

DHMH 17 Rev 1/2001

State

Registrar

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

UG

Jinson Park, CRNP, Manor Care Woodbridge Baltimore, MD

32. Registrar's Signature

29c. License number

R143094

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13, 2009 August 12:00 AM Carol Ann Marcin 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Aug. 3, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Hours Days 1 □ M 2 🔀 F 1946 Pennsylvania 63 165-38-7907 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 No Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21015 510 Fountain Green Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 2 X No 1 ∐Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Travel 5+ Travel Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa (unk) Loffelhardt John B. Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 510 Fountain Green Rd., Bel Air, MD 21015 Stephen Marcin / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-17-09 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. 23a. Part 1. Enter the disease, or composhock, or heart failure. List only o Immediate Cause (Final Brain Herriation disease or condition resulting in death) Due to (or as a consequence of): Intracrama Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 KER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Examiner burial-tran attending physician for use as the burial Records, P.O. Box 6876 the as ò signed by ficate has been siç r, page 2 should b aro certificate Marcin, Car Division of Vital director,

Examiner Physician/Medical þ Completed Be Certification: To e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, Ite Medical Exercites must be notified a once.

**Physician** 

/Medical

/Medical

27. Manner of Death 1 Natural
2 Accident 3 Suicide 4 Thomicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

V

24 hours a

the

0

Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 □Yes 2 □No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

fson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

6 Could not be determined

500 ountain, 1)

and manner stated.

31. Date filed (Month, Day, 32. Régistrar's Signature

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 3:15 August 2009 Leland West Mann Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlotte Hall Veterans Home Charlotte Hall Mary's If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 XM 2 □ F Vrs 484-18-6850 84 1924 Massachusetts 13, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 21XINo Funeral Director Harford Maryland Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 USA 513 Westview Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: Specify: Specify: Completed by White 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) General Foreman Steel Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Leland West Mann Mona Ruth Coole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myla Lee Mann / Daughter 513 Westview Road, Bel Air, MD 21015 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-14-09 Hilltop Service Corp. Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, ature of Funeral Service Licensee MD 21009 23a. Part 1. Enfer the disease, or complications that caused be leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHF /Medical Due to (or as a consequence of) Examiner stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760g Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 12 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8/12/09 D67814 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20622 RD CHARLUTTE RANUSCA BRUNEY, CHARLOTTE HALL 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State Registrar

DHMH 17 Rev 1/2001

P.0.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.												
State of Maryland / Department of Health and Mental Hygiene  1 - State  Certificate of Death  Reg. No. 2 6 1, 3 5												
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/Medi Exami		4a. Facility Name (I	If not institution, gi	ve street and number)	2114	41	o. City, Town, o	r Location of Death	11.00	4c. Co	ounty of Deatl	
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death	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	. 13. Was	s Decedent of H	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 14	. Race - Amei Black, White	
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	-	23a. Part1. Enter shock, or hea	the disease, or cor art failure. List only	mplications that caused y one cause on each li	the death.	Do not enter t	he mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause disease or condition resulting in death)	(Final on	a END S	- 4		L DISE					Onset and Death
f /Medical Examiner		resulting in death)		Due to (or as	a conseque	ence of):	بروال					
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at A	Physician/Medica		1	d								
death certific attending pl	an/M	IF FEMALE: 23b. Was deceder		23c. If yes, outcome 1 ☐ Live birth			topic pregnanc	:v		23	ld. Date of del Month	
he dea the at thed fo	ysici	in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	□No	4□Pregnant a 9□Unknown	time of dea	ath 5□O	ther (specify)_				WOTH	Day Year
w requires that the deben signed by the should be detached				contributing to death b	ut not result	ing in the unde	rlying cause giv	ven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
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Attending Physician: r death. ector: After this certifics by the funeral director;	n: To	27. Manner of Dea	·	28a. Date of Inju	ıry 2	28b. Time of Injury	28c. Inju		28d. Describe			HOSPICE
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To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis of and manner st	f examination							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month Stella Prassinas Mitsos 6:15 A M 15, 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 XF 214-20-6492 2-17-1925 **Director** 84 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits marked other than "natural", or items 23a or 28a-f show imatic event, the "Motical Examination is retilled at Director 1 Nes 2 No MD Baltimore Sparrows Point 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8606 Oak Road 21219 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ Mo
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked other. Be James Prassinas Mariannth Stamalgis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Frank Mitsos - Son 8606 Oak Road, Sparrows Point, MD 21219 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greek Orthodox Cem 8-18-09 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home PA, 2134 Willow Spring ROad. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 Other (specify) the a 1 ☐ Yes 2 📉 No detached 9 Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ompleted peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has b 24a. Was an bage 2 autopsy performed? Yes 2 No

MITSOS STELLA

AUGUST

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<u>=</u>	sician: certific rector,	Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only	y one)				
of V	Physic this ce al dire	2	1 ☐ Yes 2 MNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 🗆	DOA Other: 4 Nursing H	lome 5 ☐ Re	esidence 6XIOther (Specify) HOSPICE				
ion	ath. ath. rr. After t	ation:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation			28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how injury occurred				
Divis	al or Atte s after de al Directo ed in by th	Certifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, fact	ory, office	28f. Location City or T	(Street and Number or Rural Route Number, own, State)				
	he Hospital n 24 hours he Funeral pletely fillec	edical (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best of my knowledge, d niner: On the basis of examination and/o itioner:	eath occurr or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the	he cause(s) and manner as stated. le, date and place, and due to the cause(s)				
	To the within 2 To the comple	Ž	29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Month, Day, Year)				
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	ク V		30. Name and address of person who	completed cause of death (Item 23a) (Ty	pe, Print)							
	<b>V</b>		MARIAM BAKIR, CRI	NP 2300 DULANEY VA	LLEY	RD. TIMONIUM	. MD 21	1093				
П	Sta	te	31. Date filed Mong, Day, gerinno	32. Registrar's Signature	.010							
	Registr	ar	RUG I D 2003 Lever D. Marie D.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh 8894 8-19-08 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 11:14 P **Grace Marie Mascott** Aug 14, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Mt. Airy Kline Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 😿 F Yrs. New JerseyNew Director 88 137-16-5804 Feb 22, 1921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Involved Event and in the Involved at 1 ☐ Yes 2 No Director Frederick Mt. Airv MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21771 U.S.A. 5632 Catoctan Ridge Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Preschool Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Burke Nora Leany P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traur 9509 Lady Bug Row Columbia, MD 21046 Tom Mascott Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Aug 19, 2009 East Hanover, NJ Fune al S⊣rvi e Licens 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. A fleart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ementa **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, signed by the attending physician Physician/Medical the as IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No P.O. detached i 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ should be 3 Probably 4 Unknown 2 🗆 No 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? kutension 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 🖼 No 2 🗆 No 1 ☐ Yes of Vital Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \bigcap \) Nursing Home \( 5 \bigcap \) Residence \( 6 \bigcap \) Other (Specify) Hospital: 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

orrest Marquess	State of Maryland / Department of Health and Mental Hygiene  1-For State Certificate of Death Reg. No. 2019 254											
Physician/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day	Year	3. Time of Death							
Medical Examine			August 11, 200	09	1910 hrs							
	,	b. City, Town, or Location of Death	1 4	c. County of Death								
	Good Samaritan Hospital	Baltimore	10.00 (5.00 4)	N/A	halass (Clata as							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min		Foreig	Maryland							
Director	216-86-7289   1XM 2 F   38 Yrs		Sept 22,	1970 Coi	untry)							
V1 È	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	on			10d. Inside City Limits							
ر <u>ه</u>	D.1.				1 Yes 2 No							
yland yland sonce	Maryland Baltimore Parkvi	10f. Zip Code	10g. Citizen of What Country?									
the Maryland or 28a-f show any tified at once. Director		21234		USA	,							
\	3433 Orlando Avenue	s Decedent of Hispanic Origin? (S	pecify Yes or No-		can Indian, Black,							
or items 23a	1 Never Married 2 Married Armed Forces?	es, specify Cuban, Mexican, Puerto		White, etc.								
ē l	3 Widowed 4 Divorced III Yes, Give Year	Yes 2 X No specify:		Specify: Whi	te							
urs aft tural' amine	or Dates:	t's Usual Occupation (Give kind of		Kind of Business/I	ndustry							
n "na al Ex	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use ret	ired)									
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner Completed by 1	9 Pain				l Painting_							
21215-0036 wld be filed within 72 hours aff Mental Hygiene. marked other than "natural" e event, the Medical Examing To Be Completed by			e (First, Middle, Maide	n Surname)								
121 ld be fil dental H narked event,	Gary E. Marquess  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin  19b. Mailin	Address (Street and Number or	1 Cutler	City or Town State	Zin Code)							
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e, MD 21215-0036 I and 2 should be filed within ' Health and Mental Hygiene, item 27 is marked other than r traumatic event, the Medical	20a. Method of Disposition 20b. Place of Disposition	ition (Name of cemetery,	Date 200	Location - City or	Town, State							
> × × > ≥	1 Burial 2 X Cremation 3 Removal from State crematory or of		/4 / /00 F	) _ 1 <b></b>	M1 - 1							
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Balt permit. Depart Impor	Inomas Gregor	Of Maryla d Baltimor	ind, Inc.	and 21228								
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	he mode of dying, such as cardiac	or respiratory arrest, s	hock, or heart	Approximate Interval							
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Fentanyl intoxication)	n			Between Onset and Death							
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f Vita	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatier	t 3 DOA Other Nurs	•	idence 6 Othe	r:							
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Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	4 Homicide determined (Specify) House	Baltimore										
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To the vithin 2 To the complet	and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Mo								
	A Town I and	O.C.M.E.		ugust 12, 2009								
- April	30. Name and address of person who completed cause of death (Item 23a)											
5 OX P		11 Penn Street, Baltimore,	MD 21201									
Stat	31. Date filed (Month, Day, Year) 2. Registrar's Signature	(c. D)										
Registra	AUS 19 2009 Januar A. Januar											
DHMH 17 Rev 1/200	ORIGINA	AL.		a a succession								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 James Matczuk August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore <u>Towson</u> Manor Care- Ruxton 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**½** M 2 □ F 93 216-09-6986 December 6,1915 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Inportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be marked once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Funeral Director Baltimore Dundalk Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 6920 Delvale Place 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 | Yes 2 tf Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by 3. Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Buyer Raytheon 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Matczuk Victoria Wojtkievicz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward J. Matczuk 932 Upper Glenco Road, Baltimore, MD. 21152 Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) August 18 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P. A.
7110 Sollers Point Road, Dundalk, Md. 21222 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner stepasthritis The law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 certificate 1 ☐Yes 2 ☑No 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) nd manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hillow 07 15X w 25

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		1 - For State Registrar	State of Maryla		artment of He rtificate of D			ene g. No 0 0	9 26440
Phys	ician	Decedent's Name (First, Middle, Last)	Rosalind	M. McC	Cov		2. Date of Death Month		3. Time of Death
/Me Exan	dical niner	4a. Facility Name (If not institution, give si		· · · · · ·	4b. City, Town, or L	ocation of Death		4c. County o	f Death Baltimore
Funer Directo		5. Social Security Number 6. Sex	7. Age (In y.	rs. last birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul 28.	Year)	9. Birthplace (State or Foreign Country) Maryland
TO		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo		allstown			10d. Inside City Limits 1 ★ Yes 2 □ No
ith the Ma or 28e-f	Directo	Maryland Baltim  10e. Street and Number	ore		10f. Zip Code	21133	10	og. Citizen of Wi	nat Country?
ore, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Ralah and Mental Hygiene, than 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event, the Modical Examinar must be natified at	by Funeral Director	9717 Eustice Road  11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces?  1  Yes 2 No No If Yes, Give Year or Dates:	İ	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No		pecify Yes or No- p Rican, etc.)	14. Race	- American Indian, , White, etc.
Maryland 21215-0036 to 2 should be filed within 72 hours aft thand Mental Hygiene. 27 is marked other then "natural", or recumatic event, the Wuckel Exami	Completed b	15. Decedent's Educ (Specify only highest grade	ation	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of wor	king	16b. Kind of Bus	oness/Industry  Of Maryland
and 21 d be filed v sntat Hygie ted othar t	o Be Co	12 17. Father's Name (First, Middle, Last) George	Rogers				ne (First, Middle, M	Maiden Sumame e Rogers	)
Maryl Id 2 should Ith and Me 27 is mark	To	19a Informant's Name/Relationship (Typ. Rev. Dr. Kevin Rogers	e, Print)		ng Address (Street ar				
0 95 5 5		20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □R  4 □ Donation 5 □ Other (Specify)	1	cemetery, cre	osition (Name of matory or other place I Ridge Cemet	1	Date :		City or Town, State ville, Maryland
Baltim permit. Pa Departmer Important any injury	once.	21. Signatur neral Service Lense	M Es		2. Name and Address	of Facility	ral Service, Faltimore, Md	2 A 21217	
Physicia /Medic Examine and pub pub	al er ច	23a. Part1. Enter the disease, of complished shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to limited the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cont	state sequence of): nequance of):	ter the mode of dying		ance		Approximate Interval Between Onset and Death
P.O. Box 68760, was the death certificate be executed by the attending physician and selached for use as the burial-transit	ian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	Gc. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)	-		23d. Date Mon	e of delivery th Day Year
- E P B	à	Part II. Other significent conditions con	tributing to death but not	resulting in the	underlying cause give	n in Part I.			ibute to the cause of death?  3 DaProbably 4 DUnknown
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ling Afte		27. Manner of Death  1 Notatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time Injury	Work	at ? es 2 □ No	28d. Describe h		
	.   <del>[</del>	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecity)			City or Tow	n, State)	er or Rural Route Number,
To the Hospitel o within 24 hours af To the Funaral D completely filled in	edical	29a. Certifier 1	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea mination and/or i	nvestigation, in my op	inion, death occi	urred at the time, d	late and place, a	and due to the cause(s)
To t To t Com	Σ	12n An	eli D.O			544	24	8-14	
		30. Name and address of person who co	Hammand 32. Registrar's S	(Item 23a) (Type s lane L	Brocklyn,	MD2	1225 5	iuite #	12
	State istrar	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature .	park				

			For State	State	of Maryl		ertificate of			giene Reg. No.2	70	26441
			Registrar  1. Decedent's Name (First, Middle,	Last)			7711110010 07		2. Date of De	Death 3. Time of Death		
	Physicia		mark			0	CAMPA	1.1	Month OS	10 ZC	Year	14:25 8 M
	/Medic Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town,	or Location of Deat		4c. County		12
			Umm	C			Bolti	more		Balt	imoı	ce
51	Funeral		5. Social Security Numbeunk	6. Sex 1₺ M 2□ F		yrs. last birthda	/ If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th ay, Year)	9. Birth	nplace (State or Foreign untry) unk
10	Director		Usual Residence of Decedent	143 W 2 L F		51 Yrs.			Jan 1,	1958		
	land ow		10a. State <b>Unk</b> 10b. County	unk	10c	. City, Town or L	ocation unk					10d. Inside City Limits
	Mary Ind	tor									Ų	ınkı□Yes 2□No
	r 28s	Director	10e. Street and Number unk				10f. Zip Code	unk		10g. Citizen of W	hat Cou	untry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examination reliated at		1							USA		
	r dea	Funeral	11. Marital Status	Armed F	edent Ever j orces? un	n U.S. 13	. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race Black	e - Amer k, White	rican Indian, , etc.
30	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ∐ Yes If Yes, G	2∐No Sive		1 □Yes 2 🛣 No	Specify:		Specify.	whi	te
15-0036	tural		15. Decedent's	Year or	Dates:	16a. Dec	edent's Usual Occu	pationunk		16b. Kind of Bu	siness/li	ndustry unk
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yland		Be (	17. Father's Name (First, Middle, L	ast) unk				18. Mother's Nai	me (First, Middle	, Maiden Surnam	<sub>e)</sub> unk	C
<u>\</u>	2 should be f n and Mental I is marked of raumatic eve	To				1						
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<u>စ</u> ်	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	Hedical		b. Place of Dis	osition (Name of		Date	20c. Location -		
ē	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🖾 Other (Sp	3 □ Removal from	State	cemetery, cr	ematory or other pla	ace)				
Baltimore, Mar	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service			or S	22. Name and Addr	ess of Facility Comy Boar	d; 655 W	V. Baltin	nore	Street
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			23a. Partil. Enter the disease, or shock, or heart failure. List of	complications that inly one cause on	caused the ceach line.	death. Do <b>n</b> ot e	nter the mode of dy	ing, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death
4.	Physician /Medical		Immediate Sause (Final disease or condition resulting in death)	_ a	Sept	ic S	hock					····
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		Jer	Sequentially list conditions, if any, leading to immediate	bDue to	o (or as a cor	sequence of):	MILL				1	
	acutec nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с								
8/60,	ficate be executed I physician and s the burial-transit		resulting in death) Last	Due to	o (or as a cor	sequence of):						
Q	physicate sthe t	dical	7/2	d								
×	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pr	egnancy				23d. Dat	e of deli	iverv
ž Ros	death certif e attending id for use as	Physician/Me	in the past 12 months?  1 □ Yes 2 □ No	4 ☐ Pre	e birth 2□ gnant at time		□ Ectopic pregnan □ Other (specify)	су		Mo		Day Year
J.	w requires that the d been signed by the should be detached	hys	9 Unknown	9□Unl	known				1			
s S	es tha gned se del	ру Р	Part II. Other significant condition	ns contributing to	death but not	resulting in the	underlying cause gi	iven in Part I.				the cause of death?
000	equir								10	Yes 2 □ No	3∏ Pr	obably 4 Tunknown
ပ္	<b>Physician:</b> The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed							24a. Was	psy p	rior to c	topsy findings available completion of cause of
<u></u>	r: The icate								1 □ Yes		leath? □Yes	2 🗆 No
VIta	siclar certif	Be	25. Was case referred to medical examiner?	Hospital:			Ot	hor:	ath (Check only			
	ding Physician: The law h. After this certificate has funeral director, page 2 s	: To	1 Yes 2 ANo 27. Manner of Death	10	npatient e of Injury	2 ER/Outpati 28b. Time	ent 3 🗆 DOA	4 LI Nursing I	T	idence 6 Oth		cify)
0	Attending F er death. ector: After by the funera	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	,	nth, Day, Yea	er) Injury	Wo	ork? ⊒Yes 2.⊟No				
DIVISION	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flat	ce of Injury ding, etc. (S)	At home, farm, s becify)	street, factory, office		28f. Location ( City or To	Street and Numb	er or Ru	ıral Route Number,
	spital ours a neral C		29a. Certifier 1 Certifying	Physician: To the	ne best of my	knowledge, de	ath occurred at the	time, date and place	e, and due to the	cause(s) and ma	anner as	s stated.
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical E	xaminer: On the			investigation, in my	opinion, death occ		, date and place,	and due	to the cause(s)
	To t	Σ	29b. Signature and the of certifier	_				se number		29d. Date signed		
			Alcho	1 Pesio	lent		-06	-		8/101.	Loug	
			30. Name and address of person v	who completed car	use of death	(Item 23a) (Type	s, Print) S Greene	2 64 7	2.14	70 A. A		7 17 61
	Sta	te	31. Date filed (Month, Day, Year)	1 mg	Registrar's S	ignature	y Greene	216	Jac/imo	( N/ ( )		-1201
	Registr		AUG 19 21	109 Den	m	B. Soa	Mad					

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heodore Parris		State of Maryland / Department of Health and Mental F  1-For State	2009 2644
		Registrar Certificate of Death	Reg. No.  2. Date of Death  3. Time of Death
Physicia Medical Exami			Month Day Year August 14, 2009 O032 hrs
nedical Exami	i ici	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deal	
		Good Samaritan Hospital  Baltimore	
Euroral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi	rs. [8, Date of Birth(MM/DD/YYYY)] 9. Birthplace (State or
Funeral Director		Months Days Hours Mi	Foreign
		216-76-0071 1XM 2 F 46 Yrs.	12-1-1962 30000 1910
any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
À .,		MD Baltimore	1 Yes 2 No
ryłan a-f si	휭	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ne Maryland or 28a-f show	Director	5427 Radecke Avenue 21206	(ISA
			Specify Yes or No- 14. Race - American Indian, Black,
ath with tlitens 23a	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerl	
er de			Specify: Black
136 thin 72 hours after ne. than "natural", edical Examiner	b b	For Dates:	
2 ho	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	etired)
0036 within 7/ iene. er than Medical	Completed	(Care Provide	e Health Care
15-00 filed with Hygien d other	Ö	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle, Maiden Surname)
21215-0036 should be filed within 7 and Mental Hygiene. is marked other than atic event, the Medica	a	Theodore. D. Parish SL. Gerald	Line Laura Harris
AD 212 2 should be h and Menta 27 is marke	ို		Rural Route Number, City or Town, State, Zip Code)
		Geraldine L. forrish 5427 Radecker	we, Balto.MD21206
re, M s I and 2 f Health If item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
imor Pages ment of tant: If		4 Donation 5 Other Specify: Carrison Torest Cometon 8	3/25/2009 Owings Mills. MD
Baltimore, permit. Pages I a Department of He Important: If ite		21. Signature of Funeral Service Licensee 22 Apres and Andrews of Locality	ve tuveral Services
<b>™</b> 57 5 € €		105 MO1553 498520000	Ed. Palto MD 21212
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. COcaine use complicating atheroscle	
, annier		or condition resulting in death)  Due to (or as a consequence of): disease and cardiome	egaly
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	ij	cause. Enter Underlying Cause  (Disease a right put that initiated C.	
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
e executed sian and ial - transit			10 77
be extician ician unial-	dical	W UNPENDED Z3a, PII, Z7, perm, E go95 9/11/0	79 11
Box 68760, earth certificate be the attending physici of for use as the burit of for use as the burit of for use as the burit of for use as the burit of for use as the burit of for use as the burit of for use as the burit of the use of the burit of the use of the burit of the use of the burit of the use of the burit of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use of the use o	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	23d. Date of delivery
68 certif	iän	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic preg	nancy Month Day Year
Sox death e atte for u	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
- 4 ×4			23e. Did tobacco use contribute to the cause of death?
cords, P.O. law requires that the has been signed by	d by	Diabetes mellitus	1 Yes 2 No 3 Probably 4 V Unknown
ds, requir	Completed		24a. Was an 24b. Were autopsy findings available
COT Taw has t	ď		autopsy prior to completion of cause of death?
tal Rec rian: The I certificate I ector, page	Ö		1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	Be	examiner? Hospital:	
f Vil	ို	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work?	sing Home 5 Residence 6 Other:  28d. Describe how injury occurred
n of viding Ph	Certification:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	Local Booking No. 11 May 17 Second 2
SiOf Attend r death ector: by the	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Divisition At Spital or At Cours after discortal Direct filled in by	E	3 Suicide 6 Could not be determined determined (Specify)	or Town, State)
E G G E			nd due to the cause(s) and manner as stated
To the Hos within 24 h To the Fur	lica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, date and place, and due to the cause(s)
To the within To the comple	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	-	O.C.M.E.	August 14, 2009
		Held Mar 1	
Ø /		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201
NV V			
	ate	31. Date filed (Morni Pay, Yar) 2009 32. Figistrar's Signature	

Registrar

### 09-06354 Charles Penningtor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

narles Penningtor	1- For State	epartment of Certificate of		Hygiene Reg.	No. 201	19 2511
Physician/	1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
ledical Examiner	0		01. 7.	Month E August 13, 2	2009 4c. County of Death	2020 hrs
	Facility Name (if not institution, give street and number)     108 West Saratoga Street	41	b. City, Town, or Location of D Baltimore	eatn	N/A	
Funeral	5. Social Security Number 6. Sex 7. Age (In	yrs, last birthday)	If Under 1 Year If Under 2	4Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birn Foreig	hplace (State or nMary Land
Director	212-33-4497   1X M 2 F	22 Yrs.	Months Days Hours	May 6,	1987 co	untry)
ıy	Usual Residence of Decedent         10a. State         10b. County         10c.	. City, Town or Location	on			10d. Inside City Limits
d e e	Maryland N/A		timore			1 XYes 2 No
the Maryland a or 28a-f show tified at once.	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	ntry?
the M a or 2 diffed	108 Saratoga Street		21201		USA	
r death with or items 23 must be no Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	er in U.S. 13. Was	Decedent of Hispanic Origin es, specify Cuban, Mexican, P	? ( Specify Yes or No- uerto Rican, etc.)	14. Race - Amer White, etc.	can Indian, Black,
er deat , or ite	3 Widowed 4 Divorced If Yes, Give Yeer	No	Yes 2X No specify:		Specify: Bla	ack
urs after tural" amine	15 December 15 Education (Chapity only highest grade complete	ted) 16a. Decedent	's Usual Occupation (Give kin		16b. Kind of Business/	
5-0036 cd within 72 hour lygiene. to ther than "natu he Medical Exant Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ost of working life. DO NOT us	e retired)	D 0 (	2 1
003 within jene. Media	12 17. Father's Name (First, Middle, Last)	ASSI	stant	Name (First, Middle, Ma	Day Care (	Jenter
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Alonzo Lamont, Jr.			a Penningto		
212 ould bould by d Ment s mark lic ever	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Street and Number			e, Zip Code)
MD nd 2 sho alth and m 27 is	Alonzo Lamont, Jr., Father		Belle Avenue I	Baltimore,	Maryland 2	21215 Town State
Ore, es lar of Hee If ite	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	crematory or oth	ner place)		•	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "nat injury or other traumatic event, the Medical Exa To Be Completed	4 Donation 5 Other Specify:		matory Inc. (		Baltimore	
Bal permi Depa Impo injur	21. Signature of Funeral Service I Consee Thomas Gr	regor Cr	ame and Address of Facility emation Socie 9 Frederick Ro	ty Of Mary] oad Baltimo	land, Inc. ore, Maryla	and 21228
Physician	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each one.	death. Do not enter th	ne mode of dying, such as can	diac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical taminer	Immediate Cause (Final disease a. Probable		.sorder			Death
	or condition resulting in death)  Due to (or as a conseque	ence of):				
Ter.	Sequentially list conditions, if any, leading to immediate course E ter Underlying Cause	ence of);				
ed nsit <b>Exam</b> iner	(Disease or injury that initiated events resulting in death) Last	ence of):				
50, te be executed sysician and burial - transit		0.7	00/ 0 00 00			
Division of Vital Records, P.O. Box 68760, within 24 hours after death Prysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transicolating Contrification: To Be Completed by Physician/Medical Expedical Control	X UNPENDED AMENDED 23a.		g894 8-20-09	vt 	23d. Date of delive	
Sox 6876 leath certificate e attending phy for use as the by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of 1 Live birth		tal death 3 Ectopic	pregnancy	Month Month	Day Year
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Vital Reco				perform 1 <b>✓</b> Yes 2		
Vital Recysician: The his certificate director, page	25. Was case referred to medical		26.Place of Death (C			
f Vid	1 Yes 2 No Inpatient		3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 -		Residence 6 Oth	er: Scene
on of nding Pl th : After e funera	27. Manner of Death 1 X Natural 5 Pending	)	1 Yes 2			
/iSiOr r Attenc ter death irector: n by the	2 Accident Investigation 3 Suicide 6 Could not be	y - At home, farm, stre	et, factory, office building, etc	28f. Location (S or Town, St		Rural Route Number, City
Division ospital or Attending tours after death neral Director: After filled in by the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the functio	4 Homicide determined (Specify)					
Division  To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		nowledge, death occur	rred at the time, date and plac tion, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)
To the Ile within 24 To the Fu complete	and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (N	
	him him, mis		O.C.M.E.		August 14, 200	9
0.1	30. Name and address of person who completed cause of deat					
51	Ling Li, MD Assistant Medical Examiner		et, Baltimore, MD 2120	)1 		
Stat		Signature Culture				

Division or Vital Records, P.O. Box 68760,

										Was an autopsy performed? Yes 2☑ No	24b. Were autopsy findings availabl prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case refer	red to medical		/				26.	Place of De	ath (Check	only one)	
examiner?	No	Hospital:	atient 2	ER/Outpatient	3 🗆 (	DOA	Other: 4	☐ Nursing I	-lome 5	Residence 6	□Other (Specify)
27. Man → of Deat 1 ✓ Natural 2 ☐ Accident	h 5	, ,	njury Day Year)	28b. Time of Injury	М		jury at /ork? □ Yes	2 □ No	28d. Desc	cribe how injury	y occurred
3☐ Suicide 4☐ Homicide	6 ☐ Could not be determined	28e. Place of	injury - At h etc. (Spec	ome, farm, stree	et, fact	ory, offic	е			tion (Street and or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only											and manner as stated. place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 08-17-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Calvert Memorial Hospital, Prince Frederick, Maryland

State Registrar

in by

Medical

within 24 hours aft

To the Funeral D

completely filled in Hospital

the

31. Date filed (Month, Day, Year)

**AUG 19** 

32. Pegistrar's Signature racks

Mas.

1	mark!	Exami
		Funera
	Ь.	Director
AUGUST 16, 2009 6:45 a.m.	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Evaninar must be notified at one
4		Physiciar /Medica
		Examine
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	b	To the H within 24 To the Fu сотрые

		1 - State C	f Marylan		artment of F rtificate of		Mental Hygi	ene 20	09	26445
sicia edic		1. Decedent's Name (First, Middle, Last)  RHONA  LURIE			POLITZE	R	2. Date of Death Montb AUGUST	16, 200		Time of Death
min		4a. Facility Name (If not institution, give street and nu STELLA MARIS HOSPICE			TIMONIU			4c. County of BALTI	MORE	
ral tor		5. Social Security Number 216-22-4333 6. Sex 1 □ M 2 X F	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		928	Country)	(State or Foreign
4	:	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d.	Inside City Limits
	tor	MD BALTIMORE	BA	LTIMOR	E					1 □Yes 2 X No
and the facilities of	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country?	
100		1 GRISTMILL COURT #104	edent Ever in U	6 12 1	21208	diepopie Origin?	Specify Ves or No-	USA 14 Bace	- American I	Indian
	Funeral	Armed Formation 1 □ Never Married 2 Married 1 □ Yes	orces? 2 🕱 No				Specify Yes or No- rto Rican, etc.)	Black	, White, etc.	in Idian,
EXE	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or D	ve lates:		1 □Yes 2 No	Specify:		Specify:	MHIII	
100	lete	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of we	orking 1	6b. Kind of Bus	siness/Indust	ry
E a	Completed	Eiementary/Secondary (0-12) College (	1-4or 5+)	1	MAKER	0)		OWN HO	ME	
ury or other traumatic event, the mortest Exemples.	Be C	17. Father's Name (First, Middle, Last)				l	ame (First, Middle, M.			
ance	户	BENJAMIN	KLC	TZMAN		LILLIAN			DIAMON	
Iraun		19a, Informant's Name/Relationship (Type. Print)			,		Rural Route Number,	•		de)
orner		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of	i		Oc. Location - 0		State
ry or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State AN	SHE"EM	ONAH ATTZ	08-	18-2009	BALTIMO	RE, ME	)
any mjr	33	21. Signature of Funeral Service Licensee	11.	The PE	. Name and Addre	ess of Facility S	OL LEVINS	ON & BR	OTHĒRS	S, INC.
15 OI		23a. Part 1. Enter the disease, or complications that	M				ROAD, PII		-	
	8 1	shock, or heart failure. List only one cause on	each line.					or,	Int Or	pproximate terval Between nset and Death
ian cal		resulting in death)	NIC OBS' (or as a consec		E PULMON	IARY DISI	SASE			
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100	iner	Sequentially list conductors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death Last	(or de di consec	ruence of):						
ine buriar-transir	Examin	that initiated events c resulting in death) Last Due to	(or as a consec	uence of):						
200	dical	d								
20	(D)	IF FEMALE:								
in in	ian/	23b. Was decedent pregnant in the past 12 months?	itcome of pregn birth 2☐ Feta anant at time of	al death 3	☐ Ectopic pregnan	су		23d. Date Mor	e of delivery oth Da	y Year
nauci	Physician/M	1 ☐ Yes 2 ■No 9 ☐ Unknown 9 ☐ Unk		ueaui 51	Other (specify) _					
e nela	by Pr	Part II. Other significant conditions contributing to	leath but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	acco use contr	ibute to the o	cause of death?
חחחח							1 ☐ Ye	s 2 No	3 Probabi	y 4X Unknown
200	Completed				<del></del>		24a. Was an autopsy	, b	rior to compl	findings available letion of cause of
r, pay								<b>∑</b> No 1	eath? □Yes 2[	□No
ipietely filled in by the funeral director, page z snould be detached for use	o Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital:	Inpatient 2	ER/Outpatie	nt 3 🗆 DOA Oti	har	eath (Check only one Home 5 Reside		er (Specify)	HOSPICE
iei a	n: To	27. Manner of Death 28a. Date	of Injury oth, Day, Year)	28b. Time o			28d. Describe hor			nosi ton_
i i	catio	2 Accident investigation			M 1 =	Yes 2 □ No				-
in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Plac build	e of Injury - At h ling, etc. <i>(Sp</i> ec	ome, farm, sti fy)	reet, factory, office		28f. Location (Str City or Town		er or Rural R	oute Number,
nalli		29a. Certifier 1 ☐ Certifying Physician: To the								
pretery	Medical	(Check only 2 Medical Examiner: On the	basis of examin oner stated.	ation and/or ir						
8	Σ	29b. Signature and title of certifier				se number		d. Date signed	(Month, Da	y, Year)
						5025	-1	8/1	7/09	·
		30. Name and address of person who completed cau  MARIAM BAKIR, CRNP 23			Print)  LLEY RD.	ТТМОМТ	UM, MD 210	93		
Sta	te	31. Date filed (Month, Day, Year) 32.				LAUVIL	, .w 21			
gistr	ar	AUG 19 2009 A	eur ,	d. As	Wes					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 15, 2009 8:30 P. M August JOSEPH PAUL RIEGER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6307 Weidner Avenue Baltimore 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Hours **Funeral** Months Days Min. 1**X** M 2□ F 86 June 11, 1923 218-16-2245 Maryland **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits f show 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland N/ABaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6307 Weidner Avenue <u> 21212</u> U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Attornev Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John August Kossowske Katherine Rieger ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun once. 6307 Weidner Avenue Baltimore, Maryland 21212 <u>Gloria C. Rieger</u> (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Charles Borromeo Ch. Cem. 8-19-09 Pikesville, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL CELL CARCINOMA ETASTAT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate h funeral director, page 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred al or Attending P s after death. I Director: After t d in by the funera 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide filled in t To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00032639 wol er 30. Name and address of person who completed caust of death (Item 23a) (Type, Print) 120 SISTER PIERRE FIR TUWSON MO 21204 TIMOTHY HERYMY MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG neur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Finie of Death Dav Year **Physician** 2009 Miriam Walker Ripple August 9:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Four Seasons Assisted Living Bel Air Harford If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Hours Days 1 □ M 2 🗓 F 217-12-8850 Director 88 Aug. 10. 1921 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director Maryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 407 Lorraine Street 21001 Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Completed by Specify: 3 V Widowed 4 □ Divorced White Year or Dates: "natural", 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Telephone permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Mesone. Elementary/Secondary (0-12) College (1-4or 5+) Fraud Specialist Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George Robert Walker Hazel Bowman Holloway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marylee Gorman / Daughter 407 Lorraine Street, Aberdeen, Maryland, 21001 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 38/17/2009 Timonium, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signa 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Atherosclerotic CARDIOVAS &ulak **Physician** ten years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ∐Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (sAssited Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ∰ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. d35522 30. Name and address of perein who completed cause of death (Item 23a) (Type, Print) BEL AIR

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

NORTH

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 5.50 VERNON LEE REINHARDT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore osedal o uare ITal Birthplace (State or Foreign Country) Year If Under 24 Hrs. (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 🔀 M 2 🗆 F 214-40-3895 Usual Residence of Decedent Maryland Director 67 May 26, 1942 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location If than "natural", or items 23a or 28a-f show 1 ☑ Yes 2 ☐ No Directo Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 4854 Hazelwood Ave. USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status I □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Dep-rtment of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic event, it again, injury or other traumatic event, it again. Grocery Manager Grocery Store 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည John Adam Reinhardt Lvdia Marie Reiss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Reinhardt / Son 2806 Lanarkshire Way, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donation Hilltop Service Corp. 8-19-09 Towson, Maryland 21. Signature of Juneral Service Licenses <sup>22. Name and Address of Facility</sup> McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that au ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute **Physician** Myccardia Hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20 YEARS NONORON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunfal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 ANo 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide

State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

William Andrew Regie

AUG 1 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B2. Registrar's Signature

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

sklin Square Dr Baltimore

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 13, 2009 3:20 P M AUGUST JOYCE MARGARET ROSS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🖾 F 71 1937 Nov. 217-34-5116 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "ladical Experiment is ust be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 1710 Stokesley Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Should be filed within 72 hours after to the Health and Mental Hygiene. 1 ∐Yes 2½ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔣 No Specify: Specify. ģ White 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Auto Manufacturer</u> Scheduler 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Margaret Diegert Charles Harold Cowan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2713 Clever Lane, Churchville, Maryland 21028 Debbie Ahmed / Daughter 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State <u>~</u> 5 Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 8-21-09 Elkridge, Maryland M Comas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer **Physician** 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Pulmonary Distate Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Hlnknown 9 Unknown þ signed b I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 XYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 X No 1 🗆 Yes 2 No 1 □ Yes After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

68760, Box P.0. Records, Vital

timore, Maryland 21215-003

certificate has To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Jspital o.
4 hours after dec.
-vral Director; Andre in by the for

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baru 500

29b. Signature and title of certifier

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year) AUG 19 2009 pper chisapake 32. Registrar's Signature

and manner stated.

H00 67817

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) august 13, 2009

Disce, Bel Air, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2009 5:20 Am George Adolph Stewart Jr. 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Blakehurst Towson 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days Hours 1**X** M 2 □ F 87 Maryland 218-26-8832 **Director** October 17 Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director Baltimore Baltimore 1 ☐ Yes 2XXNo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ö and Mental Hygiene. is marked other than "natural", or items 23a or cumatic event, the Medical Examiner must be r Funeral 21210 6003 Lakehurst Dr. United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 X Yes 2 Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: rear or Dates 1943-63 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) executive insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic ew Eleanor Wolf George Adolph Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn M. Stewart/wife 6003 Lakehurst Dr. Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. Oct. 2,2009 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses tchell-wiedefeld Funeral Home, 00 York Rd. Baltimore, MD 2 6500 York Rd. 23a. Firt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lom Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performe To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director, After this certificate h completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မှ 1 Inpatient 2 ER/Outpatient 3 DO/ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the bearty my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

George Honnawi, MB

George Honnowing

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

555 W TOWSONTOWN BLVD, TONSON, MD Z1204

29d. Date signed (Month, Day, Year)

12009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** 4645 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 12/22/1929 **Funeral** Months 79 MD **Director** 218-22-2783 Usual Residence of Decedent the Maryland 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Actical Examinar must be notified at MD 1 □Yes 2 No Montgomery Rockville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any lipity or other traumatic event, the Medical Examinar manal 1908. 20854 USA 6121 Montrose Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physicist Government 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fredel Sugar Bessie (Unknown) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11014 Kenilworth Ave Box 335 Garrett Park, MD 20896 Judith Sugar, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/17/2009 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs, 21. Signature of Funeral Service Licer 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 □ Yes 2 □ No certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 2009 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)

**AUG 19** 

MONTROSE DD ROLLVILLE, HDZO85.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 0630 AM Sessions August 15 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center University BAIT: more of If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 08 16 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 121.52.3686 1 M 2 □ F NY Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f shor Exeminer must be notified at Baltimore Randallstown MD 1 □Yes 2 No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Southall by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced "natural", Completed er than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Aviation Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Administration 12th grade Neurs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental naries Walker Sessions Eugenia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau S Rai Idellitown MD 21133 tananne l NIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 19/09 Greenmount ( Battmore, MD 21. Signature of Funeral Service Licensee C. Greene Funeral services Jaushn Randaustown MD 21133 Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): the death certificate be executed that initiated events resulting in death) Last ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown this certificate has been signed by a director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9650 15 2009 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 5 BNtimore MD

State Registrar

31. Date filed (Month, Day, Year)

19

AUG

ST

22

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Physician/ Month AUGUST 16, SIEGLINDE DOROTHEA SMITH 4:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER @ GBMC TOWSON BALTIMORE 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Oct. 21, 1934 7. Age (In vrs. last birthdav) Funeral 9. Birthplace (State or Foreign Days Months 1 □ M 2 🕱 F Hours Germany Director 213-36**-**3769 74 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1835 Stevens Drive 21040 USA 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. traumatic event, the Medical Examiner 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Specify Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Education Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Fritz (nmn) Pusch Else (nmn) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie R. Martins / PR 330 Guppowder Road, Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Durial 2 Dremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-18-09 Towson, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fature. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Complications of disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordenying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law performed? Yes 2 No After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: At mipleted filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 00 R149194 August 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian Grant charles St. Baltimor, MD 21204 6701 Horm 31. Date filed (Month, Day, Year) gistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 46 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE LOCH RAVEN VETERANS HOSPITAL 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-14-1920 If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min VIRGINIA 1**⊠** M 2□ F 89 Yrs. W. 552-28-2942 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event and two rother traumatic event, the Medical Event and the notified at ROSEDALE 1 ☐ Yes 2 XNo BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 U.S.A. 1920 ELLINGWOOD ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 [XYes 2 □ No If Yes, Give Year or Dates: WW I I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PORT CITY PRESS LINE & TYPE OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (FLETCHER) SADIE GUY Ε. SAVILLE, SR. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ROSEDALE, MD 21237 19a. Informant's Name/Relationship (Type. Print) 1920 ELLINGWOOD ROAD ROSEDALE, MD DOROTHY E. SAVILLE/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-17-2009 PARKVILLE, PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME v & Licensee 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Tai /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐Yes 2 Mo 1 ☐ Yes 2,8 26. Place of Death (Check only o e) 25. Was case referred to medical examiner? funeral director, Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 17th 2009 Month **Physician** SCOTT HERBERT M. 10:15 PM AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GENESIS OF PERRING PARKWAY PARKVILLE BALTIMORE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 3 / 1 6 / 1 9 1 7 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 MM 2 □ F 217-03-2345 92 MARÝLAND Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director ROSEDALE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 1400 ROSEWICK AVENUE 21237 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Almed Foldes: 1, Pes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DRAFTSMAN MARTINS 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JAMES** SCOTT BETZEL LILLIAN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) law of Health BETTY LOU MUELLER/SISTER 7805 WINTERHAVEN ROAD BALTIMORE, MD 21237 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If i any Injury or once. = 5 PARKWOOD CEMETERY 8/21/09 BALTIMORE, MD 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Se 1211 CHESACO AVE BALTIMORE, MD 21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Aortic Stenosis SEVEYE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ulmonan Gaguerniany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 Other (specify) ed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by renal failure 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown disease 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe pertension 1∐Yes 2⊠No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗷 Nursing Home 5 🔲 Residence 6 🗍 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d, Describe how injury occurred 5 Pending investigation 1 X Natural after death.

Director: At in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

31. Date filed (Month, Day, Year) AUG 19 2009

29b. Signature and title of certifier

Jaema



30. Name and address of person who completed cause of death (Ithm 23a) (Type, Print) 1801 Wentworth

and manner stated.

Chonva

29c. License number

Parkulle

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18th 2009

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Road

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mildred J. Schipper August 18 2009 9:00 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Cockeysville Baltimore 13801 York Road #306 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 8, 1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗙 F Days Hours 304-40-4395 95 Iowa Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2X No Maryland **Baltimore** Cockeysville 10g. Citizen of What Country? 10e. Street and Number 21030 United States 13801 York Road #306 TH 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Art Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Johnson Malla Sorgard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Cleveland Road, St. Michaels, Maryland 21663 ace of Disposition (Name of Pate 20c. Location - City or Town, State Mala S. Burt/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition August 19. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) de Due to (or as a consequence of) Sequentially list conditions, if any, leading to influed late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d, Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

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Maryland 21215-0036

Baltimore,

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item 27

permit. Pages 1 Department of I Important: If ite any injury or ot

Examine that the death certificate be Physician/Medical

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Certification: To

Medical

Hospital or Attending Physician: ot Division

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To the Funeral Di

completely filled in

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Registrar's Signature

AUG 19 2009

Please Type or Print in Black Indelible Ink Ensure All Conies Are Legible AMEND ITEM#8 Per FH, 6894, 8/26/09, WS/ #5per FH, 6896, 10/28/09, WS/ State of Maryland / Department of Health and Mental Hygiene

1 - For Amend #7 per FH g894 8/27/09 TT

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7, 2009 Month Year **Physician** CHARLES JAMES TRUITT JR 17 12:04A M August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1928) Jan 12, 1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 215 = 22 = 2002 **Funeral** Days Months Hours -22-2002 82 Mary land **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 □Yes 2□No Director Maryland Harford Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3205 Suffolk Lane 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10 Ares 2 □ No Korea If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married > Married 21215-0036 1 □ Yes 🏋 No Specify White ð Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than amy injury or other traumatic event, ITE M. 2006. College (1-4or 5+) Special Agent Insurance Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles James Truitt Sr Catherine Volkert မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) E. Marie Gurley Truitt Wife 3205 Suffolk Lane Fallston Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gardens Aug 20,2009 Timonium, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FMAtchell-Wiedefeld Funeral Home Inc ionature of Funer mnis 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) P.0. 9 I I Inknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 □Yes 2 □No Vital 1 ☐ Yes Physician: director 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To oţ After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident investigation by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely oneX Nurse Practitionerner stated. within 2 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

State Registrar MARIAM BAKIR,

31. Date filed (Month

CRNP

AUGUST

CHARLES

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 17, MARIAN FARINHOLT THOMSEN 2009 /Medical 9:50 P M 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BLAKEHURST RETIREMENT COMMUNITY Towson Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct 15, 9. Birthplace (State or Foreign 1 □ M 2 🂢 F Days 216-46-4709 96 Director 1912 Virginia Usual Residence of Decedent 10a. State 10b Counts ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road Funeral 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White "natural", Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within 7 al Hygiene. I other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Residence 17. Father's Name (First, Middle, Last) 2 should be fill and Mental F Be 18. Mother's Name (First, Middle, Maiden Surname) John Leroy Farinholt ပ္ Mary Anita Daughtry 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara T. Huffman (Daughter) 6338 Golf Course Square, Alexandria, Virginia 22307 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdns 8/20/09 Timonium, Maryland 21. Signature of Functal Service vicensecurin MÎTCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumana /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Ulsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy signed by the a Day 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ OPD Completed peen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown has 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 No Dementis funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury the 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CENT praditiones R048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARON M. KERNERNA W. JOPPA Rd towson 1055 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year 7:20 Jean F. Tesnohlidek 13. 2009 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 204 Months Days Hours 355-12-4203 84 Yrs **Director** 01/24/1925 ILUsual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show MDDirector Montgomery Silver Spring 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11113 Lombardy Road 20901 USA by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Insurance ges 1 and 2 should be filed and 1 filed and Mental Hygins of Health and Mental Hygins of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Charles Lonnegren Helen Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Finkelstein, daughter 11113 Lombardy Rd. Silver Spring, MD 20901 permit. Pages 1
Department of Hi
Important: If iten
any injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/17/2009 Beltsville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. M01539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and physician a the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending pt IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 \( \subseteq \text{Ectopic pregnancy} \) Month Year 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 M No 2 12 No 1 ☐ Yes 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the within 2 To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) HOCKO5661 8/13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olney, MD Stein. D.0 Montgonery Concret Hospital Eborch

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 19 2009

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death A 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Avo 2009 Laura Mae Timmons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bel Air Healthand Rehabilitection Center Air HARFORD Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 🖫 F Hours 79 Director 212-28-8282 Apr. 5, 1930 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 72 hours after death with 1516 Singer Road 21085 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. I ☐ Yes 2 🔀 No f Yes. Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Bennett Claude Della Flo Molisee ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Timmons / Husband 1516 Singer Rd., Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn. 8-20-09 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 21. Sign July of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preymonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): attending physician Physician/Medical as the l nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 2 No Day 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the detached Ö 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? /es 201No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ^ P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) e Hospital or Attending Phys 24 hours after death. e Funeral Director: After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) apletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 the

State Registrar

29b. Signature and title

Benjamin

31. Date filed (Mog

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee, MD

DHMH 17 Rev 1/2001

Revolution St. Registrar's Signatur

29c. License number

Havrede Grace, MD 21078

29d. Date signed (Month, Day, Year)

August 17, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 18, 2009 1:30 A M MARTHA FRANCES TAYLOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GILCHRIST CENTER @ GBMC TOWSON Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours July 8, 1937 1 □ M 2🏋 F West Virginia **Director** 235-52-8406 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 424 Enfield Road 21085 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Janie Grav Ireson Jay (nmn) Robbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
424 Enfield Road, Joppatowne, MD 21085 William I. Taylor / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 8-24-09 Towson, Maryland . Signular & Funeral Service Lice McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each lin Immediate Cause (Final Onset an eath must true Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has I autopsy 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\overline{\Phi}\) ther (Specify) 2 🔊 No Hospital: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Matural 5 Pending Accident Investigation after death completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours a Medical 29a. Certifier 🞾 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the f only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tow sur NO 670 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			For State Registrar		State o	f Marylar		artmer ertificat				Mental Hygiene Reg. No. 2009 261				
	Physici	an	1. Decedent's Name (F		Last)							2. Date of De Month	Day	Year	3. Time of Death	
	/Medic		Saharia T  4a. Facility Name (If no		rive street and nu	mber)		4h City	Town or	r Location	of Death	August		2009 County of Death	1125 a <sup>™</sup>	
	Examir	ier	Greater Ba				r	, ,	wsor		or Bourn			altimore		
	Funeral		5. Social Security Numb		. Sex	7. Age (In yrs.		) If Under	1 Year	If Under		8. Date of Bir (Month, Da	th	9. Birth	nplace (State or Foreign untry)	
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	r 28a-f show	rect	MD Ba	altimo	16	Ba	altimo	re 10f. Zip	Code				10a. Citiz	zen of What Cou	untry?	
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2 0	urs after dea al", or items Exentine to	E.	1. Never Married	2 Married	Armed Fo 1 ☐ Yes If Yes, Gi	2 No		1 ☐Yes		Specify:		Rican, etc.)		Black, White	, etc.	
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	be filed within 72 ho ntal Hygiene. d other than "natul event, the Modes!	Be	17. Father's Name (Firs	st, Middle, La	st)	1	⊥ ⊥n:	fant		18. Mothe	er's Name	(First, Middle	Maiden S	Infant Surname)		
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ary	s 1 and 2 should be filed v f Health and Mental Hygic Item 27 is marked other t other traumatic event, th	_	19a. Informant's Name	/Relationship	(Type. Print)		19b. Maili	ing Address	(Street	and Numb	er or Rura	al Route Numb	er, City or	Town, State, Z	ip Code)	
ΥZ	and 2 ealth n 27 i	. 3	Greater Bal	timore	Medical	Center	670	l N. (	harl	les S	treet	t; Balt	imore	e, MD 21	1204	
ore >	ges 1 t of H If iter or oth		20a. Method of Disposi 1 ☐ Burial 2 ☐ C		☐ Removal from:		Place of Disponentery, cre	osition (Nar matory or o	ne of ther plac	e)	D	Pate	20c. Loc	cation - City or T	own, State	
공불	: Pag tmen tant: jury		4 ☐ Donation 5 €	Other (Spe	cify)in stat						-					
Saharia Baltimore, Maryland	permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any Injury or other trau		21. Signature of Funeral Rona	Id S.		rector		2. Name ar				, 655 <sub>1</sub> W	. Bal	ltimore	Street	
0			23a. Parl 1. Enter the c	lisease, co	mpli tions that c ly one cause on e	aused the deat	h. Do not en	iter the mod	le of dyin	mary, ig, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between	
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	/Medical		resulting in - th)	4	a. Due to	or as a conseq	uence of):	100	VIT	100					5 min.	
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
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	res th signed	þ	Part II. Other significar	nt conditions	contributing to de	eath but not res	ulting in the u	ınderlying c	ause give	en in Part I					the cause of death?	
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₹	Physician: r this certificaral director, p	Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No	to medical	Hospital:		150/0		. Othe			(Check only o				
Division of Vital Records,	g Phy er this eral d	Certification: To	27. Manner of Death		-	npatient 2 of Injury h, Day, Year)	28b. Time o		8c. Injury	y at		me 5 ∐ Resi 28d. Describe		Other (Spec	ify)	
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	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Medical	29a. Certifier (Check only one)	Certifying I Medical Ex	Physician: To the aminer: On the batter and manu	best of my kno asis of examina ner stated.	owledge, dea ation and/or in	th occurred nvestigation	at the tir , in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title	of certifier		11	^	290	License	e number			29d. Date	signed (Month	, Day, Year)	
			<ul><li>#</li></ul>	8	_/		-7		1)01	208	930	2	8	3/10/	09	
			30. Name and address	of person wh	o completed caus	e of death (Iten	n 23a) (Type,									
			HOM	wit	> SI-Br	ERPEL	0	6	Sle	N 2	0	HARL	X5	st. 2	1204	
	Sta	te	31. Date filed (Month, E	Day, Year)	2. R	egistrar's Signa	ture									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #2 per MD 8894 8/19/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Aug . Jul 12, 2009 **Physician** 12:46 p Oscar B. Turner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Joseph Richey Hospice, Inc. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 → M 2 ☐ F Maryland Director Nov 6, 1929 220-20-2645 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 Yes 2 No Columbia Director Howard Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21044 10528 Cross Fox Lane Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □No Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Black Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ! Hygiene. other than " Elementary/Secondary (0-12) Private Company College (1-4or 5+) Truck Driver ulth and Mental Hygie 27 is marked other raumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Turner Robert Turner Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau 7503 Haystack Drive Windsor Mill, Maryland 21244 Michelle Turner Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 08/17/09 Baltimore, Md. Woodlawn Cemetery & Chapel 4 Donation 5 Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compilcations that cause the death. shock, or hear railure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** METaslA /Medical Due to (or as a consequence of): Examiner Metastal Socientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as the attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Ś 1 Ses 2 No 3 Probably 4 Unknown Record funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Vital 1 □ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ot 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pi 24 hours after death. Funeral Director: After ti 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HOO 62554 - DO 08-12-2009 Richey JUSEPH Hospice 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

CYNTHIA

AUG 1 9 2009

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Baltimore

MD 21201

			For State Registrar	State of Mar	•	epartmer <i>Certifica</i> :				ental Hy	/giene Reg. No.	200	9	26464
	Physici		1. Decedent's Name (First, Middle, La	1						2. Date of D Month	y Day	Yea 2 <i>0</i> 0		Time of Death
	/Medi Examir		4a. Facility Name (If not institution, gl			4b. City	//	Location	of Death	7400		County of De		<u> </u>
	Funeral Director		Social Security Number     6.	Sex 7. Age	(In yrs. last birti	hday) If Unde Months	r 1 Year_	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth Pay, Year) .6 192		Birthplace Country) ary L	e (State or Foreign and
	aryland show	ō	Usual Residence of Decedent  10a. State 10b. County  Md. Anne Art		10c. City, Town	or Location yn Park								Inside City Limits 1 □Yes 2 <b>K</b> 1No
	with the M a or 28a-f	Direct	10e. Street and Number 703 Matthews Ave				p Code	225			10g. Citiz	zen of What		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, I'm "ledfeld Examination once.	by Funeral Director	11. Marital Status  1 □ Never Marrled 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forces? 1		13. Was Dece If Yes, spe 1 □ Yes	edent of H ecify Cuba	ispanic Or	n, Puerto P	cify Yes or N Rican, etc.)	0-	14. Race - Ai Black, Wi Specify: W	nite, etc.	,
Baltimore, Maryland 21215-0036	d within 72 ho giene. er than "natur i, the Medical I	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)		Decedent's Usu (Give kind of wo life. DO NOT u Aeros	ork done d ise retired	ation during mos l)	st of workin	g		nd of Busines		ry
yland	ould be file Mental Hy arked oth atic event	To Be (	17. Father's Name (First, Middle, Las. William Andrew S	•						First, Middle Rees	*	Surname)		
, Mar	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship  Victor Vykol, Son	,	703	Mailing Address  Matthe	ews A		Balto	o. Md.	2122	25		, 
limore	. Pages 1 Iment of H tant: If ite jury or ott		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Cedar	Disposition (Na , crematory or d Hill Cel	other plac Metei		8/21/	09	Balt	to. Md	•	
Ball	permit. Departri Importa any Inju		21. Signature of Funeral Service Lice	nsuccor	hi"	4001 R:	itchi	ie Hw	y. Ba	lto. M	ld. 21	Servi 1225	ce P	.A.
	Physician /Medical Examiner		23a. P+11. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that caused the cone cause on each line.  a.   Due to (or as a cone cause)	ular F	brille	/		cardiac or	respiratory a	arrest,		Int	proximate erval Between set and Death
		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	ary /t	Very	Di	hon Seaso	e				20.	years
P.O. Box 68	eath certi attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 P No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 ☐ Ectopic p 5 ☐ Other (s <sub>i</sub>		/			2	3d. Date of o	delivery Day	/ Year
rds, P	w requires that the dispersion is been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but r	not resulting in	the underlying o	cause give	en in Part I			tobacco us Yes 2□	_		ause of death?
	: The law red cate has bee , page 2 shor	Completed								24a. Was auto perfe 1 ∐Yes		prior t death	o comple	findings available etion of cause of
V:It	nding Physician: Th. th. : After this certificate : funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	or.		(Check only				
of	Phy er this eral di	Ë	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Out		JA	4 L N		e 5 ☐ Res 3d. Describe		Other (S)	oecify)	
rision	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Certification: To	1 Natural 5 Pending investigatio 3 Suicide 6 Could not b	(Month, Day, Y	ear) Inj	jury M		? ∕es 2 □	No				Rural Ro	ute Number,
وَ	spital or nours afte neral Dire / filled in t		29a, Certifier 1 Certifying Pi	hvsician: To the best of	mv knowledge.	death occurred	at the tin	ne, date ar	nd place, a	City or To	wn, State)	and manner	as state	d
	ne Ho n 24 l ne Fu pletel	Medical	(Check only 2 Medical Examone)	miner: On the basis of en and manner state	xamination and	/or investigation	n, in my o	pinion, dea	ath occurre	d at the time	, date and	place, and d	ue to the	cause(s)
	To the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confi	Ň	29b. Signature and title of certifier	august 1	no		c. License		02	2		e signed (Mo		
	12		910701	inych mo	th (Item 23a) (T	Type, Print)	K Ha	nove	- Sh	cet 1	Salhin	we M	wy!	2009 and 21225
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1 .0 1	,						/	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician volberta Villeda /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Co. Futurecare Cherrywood Nursing Home Reisterstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/7/1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex Funeral Months Days Hours 1 □ M 2 🖾 F 85 565-02-4745 Director Honduras Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County of Haalth and Mantal Hygiana. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumstic event, the Medical Express must be notified at MD Baltimore Co. Reisterstown 1 ☐ Yes 25TxNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pagas 1 and 2 should be filad within 72 hours aftar death with 204 Cantata Ct. 21136 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 21⁄2 No If Yes, Give 1 ☐ Never Married 257 Married Specify: Honduras Baltimore, Maryland 21215-0020 1⊠ Yes 2□ No Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kitchen help Restaurant 18 Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Silveria Villeda Segundo Raminez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angel Urbina 204 Cantata Cr., Reisterstown, MD 21136 husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I important: if ite any injury or ot once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/15/09 Carroll Cremation Ser. Hampstead, MD Fune I Service Licensee 22. Name and Address of Facility 21. Signature 11824 Reisterstown Rd J Wayne Osteling Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) METASTATIC HEPATO CILLULAR CALCINOMA /Medical Examiner Physician/Medical Examine usa as the burial-transit or Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of). Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 2 PN0 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA Aftar this funaral of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No aftar daath Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funeral Dis complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ş 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 142009 R088852 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 HAIN STASST \$ 200, REISTENSTOWN, MARY/AND 21136 KATHLEEN C SIAMOND 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State **Hegistrar** 

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10:10P 2. Date of Death Physician/ Authorst 17 Day 2009 Year ELIZABETH AUSTIN WINTERNITZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 M 2 X X Months Days Hours. May 8, 1919 North Dakota Director 336-12-3769 90 Usual Residence of Decedent 28a-f shov 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2(1) No Baltimore Cockeysville Maryland Oe. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 USA 13801 York Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: If Yes, Give than "natural", 3 Widowed 4XX Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frances Ellsworth Charles Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Charles Austin Winternitz Son 6900 Petworth Road Baltimore, Maryland 21212 20a. Method of Disposition
1 □ Burial XX Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date GreenMount Crematory | Aug 19,2009 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Family CHELL-WIEDEFELD FUNERAL HOME INC Sir nature of Funeral Ser Ace License 6500 York Road Baltimore, Maryland 21212 Ken 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovasular Accident disease or condition resulting in death) ays Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Depression certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 61 Christ 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of

To the Funeral Direct

completed filled in by Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Balkmore 21204 hailes 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 9 2009 AUG Registrar

			for State Registrar	State of	ate of Maryland / Department of Health and M Certificate of Death					Mental Hygiene Reg. No. 2000 251, 67				
	Physici	an	1. Decedent's Name (First, Middle, La					. Date of Deat	n Day	Year	3. Time of Death			
	/Medic		David Wither		4b. City, Town, or Location of Death			8	4c. County of Death		0 909 AM			
	Examin	er	4a. Facility Name (If not institution, gi	/e street and numb	oer)		4b. City, Town,	MOSE			4c. Coun	ty of Death		
	Funeral				. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs   0	Date of Birth	Voar)	9. Birth	place (State or Foreign	
	Director		200-30-4922	1 <b>∑</b> M 2□F	66	Yrs.	Months Days	Hours	Min. F	eb 27,	1943	Ohio	0	
	death with the Maryland ms 23a or 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation			<del></del>		1	0d. Inside City Limits	
5-0036			MD Calver	·t		Lusl	hv						1 □Yes 2₽ No	
	or 28%	Direc	10e. Street and Number 10f. Zip Code							11	10g. Citizen of What Country?			
	ath wi	ral	11492 Rawhide Road					557		USA				
	urs after de al", or items Exemitet in	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	12. Was Decede Armed Force 1	es? [X]No		Was Decedent of fYes, specify Cu l □Yes 2 <b>X</b> No			fy Yes or No- can, etc.)		ace - Americ ack, White, ify: Wh		
ဂ ဂ	72 hou natura licel E	eted	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business/Industry			dustry	
7	iled within 7 Hygiene. ther than "r nt, the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			life. DO NOT use retired)  claims analyst				social securit			itv adm	
yland 2		S	12 17. Father's Name (First, Middle, Las	<u>Z</u>		C1	aims and	<del>-</del>	er's Name (F	First, Middle, N				
	ld be f ental ked o ic eve	To Be								Bryan				
ar	should and Ma s mark umati	۲	19a. Informant's Name/Relationship	(Type. Print)		1	ng Address (Stree				-			
baltimore, Ma	and 2 ealth a n 27 is		Vernon Fisher/friend				2901 Buckseyeland Lan			e Charlottesville,				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If it item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinar must be notified all once.	y,	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ State (Specify) in state				e of Disposition (Name of letery, crematory or other place)			e i	20c. Location - City or Town, State			
Da Da		li 7	21. Signature of Euneral Stryice Licensee Portage Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201											
	Physician /Medical Examiner	2 11	23a. Part Lenter the disease, or col shock, or heart failure. List only	plications that cau one cause on eac	used the deatl th line.	h. Do not ent	er the mode of dy	/ing, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death	
and a			Immediate Cause (Final disease or condition resulting in death)	a Peric	-		ponde						20 vin	
			1	Due to (or as a consequence of):								11.		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of).									6 M/3	
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C										
8/00,		al E	robuiting in death) East	Due to (or as a consequence of):										
200	ificate g phys is the	edical		▲d					_		1			
XOD	th cert endin	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregna			in an av			23d. Date of de		ery Day Year		
). O	by the att	Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown	1 Yes 2 No 4 Pregnant at time of dea								Month Day		
rds, r	equires the	by	Part II. Other significant continuous continuous to death out not resulting in the underlying cause given in Part I.								the cause of death?			
vital necords,	ertificate has be ector, page 2 shu	Completed	high choles terol							autopsy pr performed? de		prior to co death?	ere autopsy findings available ior to completion of cause of aath? □ Yes 2 □ No	
<u> </u>		Be C	25. Was case referred to medical examiner?											
No moising	Physi this o	2	1 Norman of Death			] ER/Outpatient     3 □ DOA     Other:     4 □ Nursing Home     5 □ Residence     6 □ Other (Specify)							fy)	
	ath. r: After e funer	ation	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year) 6 Could not be determined  28e. Place of Injury - A building, etc. (Special County)			rear) Injury M Work?  M 1 ☐ Yes 2 ☐ No  r - At home, farm, street, factory, office 28f				<ul> <li>28d. Describe how injury occurred</li> <li>28f. Location (Street and Number or Rural Route Number, City or Town, State)</li> </ul>				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:												
		edical	29a. Certifier (Check only one)  154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	Noth To t	Σ	29b. Signature and title of certifier								ned (Month, Day, Year)			
			7/1/2/2		AU4176435618928 8/10/09					9				
			30. Name and address of person who Jennifer Guy		or death (Iten	72 22	South	Green	NE ST	Heet	Baltin	5700	10515 UM	
Ag <sub>e</sub>	Sta Registr		31. Date filed (Month, Day, Year) <b>AUG 1</b> 9 200	32. Reg	gistrar's Signa	sture Sar	Kal							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug. 15° 20°09 11:30A M **Physician** Virgie Mae Woodfin /Medical c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Towson Towson 9. Birthplace (State or Foreign Country)
VI 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 1 □ M 2 💢 F 86 213-20-4743 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 1 ☐ Yes 2 No Louisville MD Blount Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt. 56 37777 USA 4710 Wheeler Rd. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3. Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Housing College (1-4or 5+) Elementary/Secondary (0-12) Development Office Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Elisa Lynch Joe Edward Nunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5101 Wright Ave. Balto, MD 21205 19a. Informant's Name/Relationship (Type, Print)
Tammy Bell/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. Aug.Date 17, 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility AFA/Stephen D.Lohrmann P.A. 8717 Green Pastures Dr. Balto, MD 21286 Approximate Interval Between Onset and Death 23a. Part 1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Vementia H(zheimers 18418 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) □Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate 1 □ Yes 2,2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/55 St, Su. Te 4(05, Touson MD 21204 MD Nor 32 Registrar's Signature 31. Date filed (Mont) State Registrar

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

Gyan

Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 10 10

			For State Registrar	State of Ma	*	epartment Certificate			d Mer		jiene'     eg. No.	9	26470
	*		Decedent's Name (First, Middle, Last)	·			-			Date of Deal		Year	3. Time of Death
	Physicia /Medic		Goldie Madeline W	ills						August	13, 20	09	6:30 A M
	Examin	_	4a. Facility Name (If not institution, give str			4b. City, To	own, or l	Location of De	ath		4c. County of	f Death	
			Genesis Elder Car				Plat		leo o	0		arle	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthe	Months	Days	If Under 24 H Hours M	in.	Date of Birth (Month, Day	, Year)	Coun	
	Director		236-48-8991 Usual Residence of Decedent		76 "				Į O	ct. 26	, 1932	west	t Virginia
	land ow		10a. State 10b. County		10c. City, Town	or Location						10	Od. Inside City Limits
	Mary I eh	ţō	Maryland Harfor	d	Edge	wood							1 ☐ Yes 2X No
	r 28g	rec	10e. Street and Number			10f. Zip C	Code			1	0g. Citizen of W	hat Coun	try?
	th with	Funeral Director	1418 Clearview Roa	d		21	.040				USA		
	dead	ner	11. Marital Status	. Was Decedent Ev	ver in U.S.	13. Was Decede If Yes, specif	int of His	spanic Origin? n. Mexican, Pu	(Specify	Yes or No-	14. Race Black	- Americ	
9	or its		1 Never Married 2 Married	1 ☐Yes 2 NO		1 ☐ Yes 2		Specify:		,	Specify:		
003	urai',	d by	3 XWidowed 4 □Divorced	If Yes, Give Year or Dates:	1							Wh;	
21215-0036	be filed within 72 hours aftar death with the Maryla la! Hyglene. Id other then "netural", or items 23a or 28a-1 eho event, the Madical Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)	(0	lecedent's Usual Give kind of work ife. DO NOT use	done di	uring most of t	working		16b. Kind of Bus	siness/inc	lustry
12	withir ane. then	d L	Elementary/Secondary (0-12)	College (1-4or 5+	)	Homemake					Own Hor	ne	
9	Hygin Hygin ther ant,		17. Father's Name (First, Middle, Last)			nonemake		18. Mother's i	Name (F	irst, Middle,	Maiden Sumame		
an	d be Bontal Ked o	To Be	Thomas Abner Woote	n				Alta	Ess	ie Fro	st		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health end Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show other treumstic event, its Medical Examinar must be notified at	-	19a. Informant's Name/Relationship (Type		19b. N	Mailing Address (	Street a					State, Zip	Code)
Ž	nd 2 alth e 27 ie		Gregory B. Wills /	Son	52	05 Wolfe	e Dr	ive. H	iahe	sville	MD 20	637	
ē,	s 1 a of Hei		20a. Method of Disposition		20b. Place of D	isposition (Name crematory or oth	e of	Ţ	Date		20c. Location - (		wn, State
Ë	Pages nent of h int: if ite iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		Memoria			-17-	09	Bel Air	. Ma:	ryland
Baltimore,	- 5 2 5		21. Signature of Funeral Service Licensee			22. Name and	Address	s of Facility					
m	Depa Impo		Hilly Millan	asker	with	1317	coke	uneral sbury 1	Rd.	Abing	don, MD	210	09
			23a. Part1. Enter the disease, or complications, or heart failure. List only one	ations that caused t	he death. So no								Approximate Interval Between
· ·	Physician		Immediate Cause (Final disease or condition	( AN)	CEN	) 4 (	01	-0n	) .				Onset and Death
	/Medical		resulting in death)	Due to or as a	consequence of	):		1 1		1000			
	Examiner		Sequentially list conditions, b.	10/12	THY	1 HTI	<u>C</u> -	401	7	IER	ノ <u>'</u>		
. 0	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	):							
Ma	and I-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a	consequence of	<u> </u>							
8760,	s be axecutad sicien and burial-transit					,							
587	ficata phys s the	Physician/Medical	d.						-				
Box 68	certif ding se a	/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome o							23d. Date	of delive	ry
ă	death a atter	clar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pred 5 ☐ Other (spec					Mon		Day Year
P.O.	t the object the acher	hys	9 □ Unknown	9□ Unknown						***			
رب م	res that the death certificationed by the attending pool detached for use as	by P	Part II. Other significant conditions conti	ributing to death but	not resulting in t	he underlying car	use give	n in Part I.		23e. Did to	bacco use contri	bute to th	e cause of death?
ğ	w require been sig should b								_	1 □ Y	es 2□No	3 🗌 Prob	ably 4 Unknown
ဝ	hasbe	Completed								24a. Was a	an 24b. V	Vere auto	psy findings available inpletion of cause of
Ž.	The late had page	E O								perfor	med? d	eath?	2 □ No
ita	artifica ctor,	Be	25. Was case referred to medical examiner?					26. Place of I	Death (C				
<u>&gt;</u>	is sign	၉	1 ☐ Yes 2 No	spital: 1   Inpatien		atient 3 DOA		4 Nursin	g Home	5 🗌 Resid	ence 6 □Othe	r (Specif	v)
Ē	£ ± ×	<b> -</b>	27. Magner of Death			ma at 100	c. Injury	at	28d	. Describe h	ow injury occurre	ed	
Division of Vital Records,	ing Phy Vitar this uneral c		1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir		c. Injury Work						
	tending Phy Jeath. tor: After this the funeral o		2 ☐ Accident investigation			М	1 🗆 Y	es 2 □No	004	Landing (G			10
Š	or Attending Phy siter death. Director: After this in by the funeral of			28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	ry - At home, farn	М	1 🗆 Y		28f	Location (S City or Tow	itreet and Numbern, State)	er or Rura	l Route Number,
Div	spital or Attending Phyours efter death.  Nerel Director: Aftar this filled in by the funeral of	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farn (Specify)	n, street, factory,	1 🗆 Y	′es 2 □No		City or Tow	n, State)		
Div	e Hospital or Attending Phy 24 hours efter death. • Funerel Director: Aftar this etely filled in by the funeral of	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm (Specify) I my knowledge, examination and	M n, street, factory,	1 🗆 Y	e, date and pl	ace, and	due to the o	m, State) cause(s) and mai	nner as s	ated.
Div	To the Hospital or Attending Phy within 24 hours efter death. Fo the Funerel Director: Affar this completely filled in by the funeral or		2 Accident investigation 3 Suicide Could not be determined  29a. Certifier Check only 2 Medical Examine	28e. Place of Injurbuilding, etc.	ry - At home, farm (Specify) I my knowledge, examination and	M n, street, factory, death occurred a or investigation, i	office	e, date and pl	ace, and	City or Tow	m, State) cause(s) and mai	nner as s	ated. the cause(s)
Div	To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours efter death.  To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification:	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	28e. Place of Injurbuilding, etc.	ry - At home, farm (Specify) I my knowledge, examination and	M n, street, factory, death occurred a or investigation, i	office	e, date and pl	ace, and	City or Tow	m, State) cause(s) and madate and place, a	nner as s	ated. the cause(s)
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		•	For State Registrar	State of Ivial year		ificate of E			eg. No. 2	09	261	171
	Physicia		1. Decedent's Name (First, Middle, La.	st)				2. Date of Deat	Day	Year	3. Time of D	
9 16	Physici: /Medic		Ellington 4a. Facility Name (If not institution, give	Parker Wood	[	Ab City Town or	Location of Death	Augus	4c. County	009	1834	PM
	Examin		The Johns Hopkins H			Baltimore			4c. Oddrity	OI Death		
200	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vear)	9. Birth	olace (State or F	coreign
l Luca	Director		N/A	<b>X</b> M 2□F	Yrs.	Months Days	Hours Min.	July 31			MD	
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	ation					10d. Inside City	Limits
	Maryland F show ed at	tor	MD Carro	<b>N11</b>	Finks	hura					1 Tes 2	X No
	r 28a	Director	10e. Street and Number		FIIRS	10f. Zip-Code		11	Og. Citizen of W	hat Cour	ntry?	
	death with the Maims 23a or 28a-f s	ral	2227 Old Westmi	inster Pike		21048			USA			
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in I	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - Americ k, White,	ean Indian, etc.	
36	ırs afte	by F	1   Never Married 2   Married  Married  Divorced	1 ☐ Yes 2 😿 No If Yes, Give Year or Dates:	1	Yes 2 X No	Specify:		Specify	W	hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra			ent's Usual Occupa		king	16b. Kind of B	ısiness/Ir	idustry	-
2	d within 72 hogiene.  r than "natur the Medical	mple	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	OO NOT use retired,	)			A / T		
	e filed withi		17. Father's Name (First, Middle, Last)			N/A_	18. Mother's Nar	ne (First, Middle,		N/A		
anc	d be file ental Hyç ced othe event,	To Be	Brandon Paul Woo				Tiffa	ny Nicole	Poole			
Maryland	shoul nd Me s mark	=	19a. Informant's Name/Relationship (		19b. Mailin	g Address (Street				State, Zip	Code)	
Ž	and 2 salth a 27 is er trai		Tiffany Nicole H			Old West						
Baltimore,	ges 1 t of He If item or oth		20a. Method of Disposition 1   ↑ Burial 2   ☐ Cremation 3	Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Location -	City or To	own, State	
ij	t. Pag tment rtant: rjury o		4 Donation 5 Other (Special 21. Signature of Fuperal Service Licen			n Mem. Ga . Name and Addres			Finks	_		
Bai	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event, once.		21. Signature of Pure all Service Liber			ine Fune			Reister		n Road 21136	
		•	23a. Part 1. Enter the disease of comshock, or heart failure. List only	aplications that caused the dea						ТП	Approximate Interval Between	een
	Physician	n i	Immediate Cause (Final disease or condition	. Hupoplas	Lic I	px+ he	art s	Under	ne		Onset and De	
9	/Medical Examiner		resulting in death)	Due lo (or as a conse			3251	41000				
	Examine	-e	Sequentially list conditions,	b	autores etc					_		
۵_	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	246 13 (Or 35 5 63) as	a >	4						
Mo.	be executed iician and burial-transit		that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
68760,	tificate be executed g physician and as the burial-transit	Medical		d								
	ertifica ng ph e as t	/Me	IF FEMALE:	One House outcome of prog	20201							
Вох	eath certif attending I for use a	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg  1  Live birth 2 Fe  4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	у			e of deliv	•	ear
P.O. F	hat the de d by the a detached	Physician/	1  Yes 2 No 9 Unknown	9 Unknown	dodin o_	· ·						
	s that the ned by	by P	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use con	ribute to	the cause of de	eath?
ş	v requires been signs should be							1 🗆 Ye			bably 4 ☐ Ur ———	
) Sec	law re as bee	Completed			•			24a. Was a autops perform	n 24b.	Were aut prior to c death?	opsy findings a ompletion of ca	vailable suse of
<u>=</u>	The	Co						1 🗌 Yes	2 💢 No	1 🗌 Yes	2 🗌 No	
Zita Zita	ysician: The l. s certificate ha director, page	Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Ninpatient 2	☐ ER/Outpatien	Othe	or:	th (Check only on ome 5 ☐ Reside		er (Sneci	f <sub>V</sub> )	
of	ling Phys n. After this funeral d	n: 70	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time or Injury		y at	28d. Describe he				
iò	adh. r: After he fune	atio	1 Natural 5 ☐ Pending investigation	n	Injuly		Yes 2 No	5.0				-
Division of Vital Records,	l or Atten after deat Director: d in by the	Certification:	3 Suicide 6 Could not to determined	28e. Place of injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. Location (S City or Town		er or Ru	ral Route Numb	er,
	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendincompletely filled in by the funeral director, page 2 should be detached for use	I Ce	29a. Certifier 1 Certifying P	hysician: To the best of my kr	nowledge, death	occurred at the tin	ne, date and place	e, and due to the o	ause(s) and m	anner as	stated.	
	e Hos n 24 hr e Fun-	edical		miner: On the basis of examinand manner stated.								)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	111.		29c. License		2	9d. Date signe	d (Month,	Day, Year)	
			1 Un 1	, Mr m	1>	Re	5-000		801	1201	9	
	Ø		30. Name and address of person who		tem 23a) (Type,	Print)	600	North Wo	fe St Ra	ltimo	re. MD 2	21287
	Sta	te		32. Registrar's Sign	nature		000	HOILII WO			, 1410, 2	- 1201
	Regist		31. Date filed (Month, Day, Year)	Cerus B.	back	1						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death WASHINGTON AUGUST 2009 1:00aM LINWOOD CHARLES 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death n/a FUTURE CARE CANTON INNER HARBOR BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) 4/25/1936 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days VIRGINIA 1⊠M 2□ F 219 32 8149 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County t**XX**es 2 □ No BALTIMORE n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 1300 S. ELLWOOD USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No IfYes, Give Year or Dates: KOREA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 □Yes 💥 No 3 ☐ Widowed 4 🙀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ROYAL CAB 12 0 CAB DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHARLES WASHINGTON UNK. SR. MARY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HELEN WASHINGTON/DAUGHTER 9822 DECATUR ROAD BALTIMORE, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/19/09 BALTIMORE, MD 4 Donation 5 Other (Specify) METRO CREMATORY 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service 211 CUECACO AME BALTIMODE

**Physician** /Medical Examiner

burial-tran

use þ detached

Physician

/Medical

Examiner

10a. State

MD

Directo

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be restituted any injury or other traumatic event, the Medical Exeminer.

Baltimore, Maryland 21215-0036

Ī	23a. Part 1. Enter the disease, or an shock, or heart failure. List only	plications that caused the death. Do not enter		or respiratory arrest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	Thromb	orc	
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequence of):			
Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):			
dica		<b>d</b> ,			
Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		ate of delivery Month Day Year
	Part II. Other significant conditions of	contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco use co 1 ☐ Yes 23 No	ntribute to the cause of death?  3 □ Probably 4 □ Unknown
Completed by				24a. Was an autopsy performed? 1 □ Yes 2 No	. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
Be	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	
0	examiner? 1 ☐ Yes 2 🜠 o	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Other: Nursing H	lome 5 ☐ Residence 6 ☐ 0	ther (Specify)
ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		f 28c. Injury at Work? M 1 □Yes 2 □No	28d. Describe how injury occu	urred
Certification: 1	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		eet, factory, office	28f. Location (Street and Num City or Town, State)	nber or Rural Route Number,
edical (	29a. Certifier 1 dertifying PI (Check only one)	hysician: To the best of my knowledge, deat miner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cause(s) and urred at the time, date and place	manner as stated. e, and due to the cause(s)
Š	29h. Signature and title of certifier	0.0	29c. License number	29d. Date sign	ned (Month, Day, Year)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Registrar

31. Date filed (Month, Day, Year)

AUG 1 9 2009

of death (Item 23a) (Type, Print)

D15872 August 18,200,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day 1203 AM **Physician** IAMES WILLIAMS AUGUST 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE HOSPITAL SECOURS | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5/16/1943 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Washington, DC 578-56-2866 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√Yes 2□No Director Baltimore MD n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 311 South Fulton Avenue 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify. Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Charter Services 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lou E. Williams / Wife 311 South Fulton Avenue, Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/21/2009 Baltimore, Maryland Bayview Crematory 21. Figure of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 9 4107 WIlkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOMYOPATHY ISCHEMIC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? OBSTRUCTIVE PULMENARY 24a. Was an autopsy perform 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physic for use as the b signed by the a \$ certificate has birector, page 2 s

funeral director,

within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760.

**Funeral** 

Director

28a-f show 3a or 28a-f show t be notified at

r than "natural", or Items 23a

7 Is marked other traumatic event, II

Department of Health Important; If item 27 any Injury or other to once.

**Physician** 

/Medical

Examiner

Health a

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

21215-0036

Baltimore, Maryland

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1)30272

29c. License number

29d. Date signed (Month, Day, Year) ANGUST 18 2009

SALTMONE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURC HOSPITAL

3 Suicide

MILLEN 31. Date filed (Month, Day, Year) AUG 19 2019 32. Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Carolyn, Belinda, Austin 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prit ce GROTAR Cheverh Prince George's Hospital ( enter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F Months Days Hours Corida 3 265+19+*8*153 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment mast be restliked at 1 Yes 2 □ No Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and 20 785 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the filed within 7 setal Hygiene. uation College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event, Induce. 2 years 17. Father's Name (First, Middle, Last) Be James Ephron David Thomas Austin I 20a. Method of Disposition 1 Burial 2 □ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Md. Lic.# 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy The 2 🗆 No 1 ∐Yes 2 1 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

P.0. Division of Vital Records, Hospital or Attending To the lawithin 2, To the F

3

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			For State	State of M	laryland		artmen			and M	, ,	13 6	no	261.75
			Registrar  1. Decedent's Name (First, Middle, Last)	)			inican	5 01 1	- Calli	- 1	2. Date of Dear	eg. No	الله ال	3. Time of Death
	Physici	an									Month	Day	Year	
iliga.	/Medic		George Robert  4a. Facility Name (If not institution, give				4h City	Town or	Location of	of Death	July	31,	2009 nty of Death	7:30 a <sup>™</sup>
	Examin	ier	, , , ,	street and namber	/								St. Mai	ru i c
	Funeral		46380 Lore Court  5. Social Security Number 6. Security Number	7. A	ge (In yrs. las	st birthdav)			gton If Under		8 Date of Birth		9. Birthr	lace (State or Foreign
	Funeral Director			<u>M</u> 2□ F	85	Yrs.	Months	Days	Hours	Min.	(Month, Day 02/05/1	(Year)	Couir	Maryland
			Usual Residence of Decedent		0.5						02/03/1	, , , , ,		naryrana
	ylan		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
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	or 28	ire	10e. Street and Number				10f. Zip				1	0g. Citizen	of What Cour	ntry?
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36	or it	by Funeral Director	1 ☐ Never Married 2K Married	1 ∐Yes 2 🔀 If Yes, Give	No		I□Yes 2		Specify:			Spe	cifv:	
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	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, if u Midical Eventing must be notified at		17. Father's Name (First, Middle, Last)				1011			er's Name	(First, Middle, i			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.	o Be	B.F. Aud							Iren				
<u></u>	shoul od Mark mark	မ	19a, Informant's Name/Relationship (Ty	ne. Print)		19b. Mailin	a Address	(Street a			al Route Numbe		wn. State. Zic	Code)
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≣	artme ortan injur		21. Signature of Funeral Service Licens	-	01	Mary		d Addres						e, P.A.
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	<b>.</b>	i Ji	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each	line.				TIM		. ,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (er er		, ,	67019	1119	7.4				-	
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			30. Name and address of person who co	mpleted cause of	death (Item 2	23a) (Tvne	Print)	٧.	00	/ -		, ,		1
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	Registr	ar	AIIG 3 ZUU	y Clean	trar's Signatu	. 194	No.							

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	Physici	an	1. Decedent's Name (First, Middle,					Date of Dea     Month	Day	Year	3. Time of	Death $\mathbf{A}_{M}$
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	/land		10a. State 10b. County	10c. City	y, Town or Lo	cation					0d. Inside Ci	ty Limits
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	or 28	)ire	10e. Street and Number	-		10f. Zip Code		1	0g. Citizen	of What Cou	ntry?	
	23a 23a ust b	Funeral Director	37595 Lockes C	rossing Rd.		20	659		USA			
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36	safte	Jy F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	d 1 ∏Yes 2 K No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Spe	ecify: Wh	ite	
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Baltimore,	ages nt of t: <b>if</b> it		1 X Burial 2 ☐ Cremation 3	H nemoval from State		sition (Name of matory or other place Peace Ceme	;0	st 14,		,		
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P.O. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1	death 3[	☐ Ectopic pregnance	у		23d.	Date of deliv Month	. ,	⁄ear
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Division	I or Attendi after death. Director: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could no	t be 290 Diago of Injury At he	me, farm, str		163 2 1110	28f. Location (S	treet and Ni	ımher or Rur	al Route Num	her
Θ	after after Dire d in b	ertii	4 ☐ Homicide determine	building, etc. (Specify	/)	,,		City or Tow	n, State)	ander or num	ar modic ream	,,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Certifying Medical Exponentian	Physician: To the best of my know caminer: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the or	cause(s) and late and pla	d manner as a	stated. o the cause(s	;)
	To the within To the comple	Me	29b. Signature and title of certifier	and marrier states.		29c. License			29d. Date si	gned (Month,	Day, Year)	
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	V.		30. Name and add ex of person wh	no completed cause of death (Item	23a) (Type,	1 *		- (	T.	eonard	town,	MD
_	15	2 1	Jenni	fer Schmidt, D.	0. 40	900 Merch	ants Lan	e Ste.	205		20650	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 11 Day 2009 Year **Physician** 1:00 A M James Daniel Alvey, Sr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital St. Mary's Leonardtown 8. Date of Birth 9. Birthplace (S. August 7,1931 Mary Tand If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 78 Yrs. 5. Social Security Number 6 Sex **Funeral** Hours Min. Months Days 213-50-8687 1 M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evander or 18 to multiput and 18 once. 1 ☐ Yes 2√ No Charlotte Hall Director Maryland Charles 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20622 USA 13241 Budds Creed Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married White 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Helen Pilkerton Joseph Harry Alvey ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13241 Budds Creek Rd., Charlotte Hall, MD 20622 Margaret A. Alvey/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) August 15, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cem. 2009 Bushwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stenons 4 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) P.O. Box 68760. led by the attending physician detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊡No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 24 hours after deat Funeral Director; 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 1006593

3 M

Alveys

Danie

James

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

Mp St. Mary's Hospital Leonardtown Indzecso

State 31. Date filed (Month of Registrar

3. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 3 2009 5:50 PM August Margaret Frances Allen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil 201 Elk River Manor Drive North East If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Months Days Hours 1 □ M 2 🕅 F Yrs. 26,1925 Maryland 219-18-5598 84 July Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Directo Maryland Ceci1 North East 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21901 201 Elk River Manor Drive by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adviana Alexander Walter Culley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 Cedar Hill Circle, North East, Maryland Debbie Boyle / Granddaughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition August 7. North East Methodist Cemetery NBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 Ø Other (Specify) 2009 North East, Maryland 21. Signature of F 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the leath. Do shock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Due to (Ir as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? bute to the cause of death? þ 3 Probably 4 Unknown Completed Be Certification: To r (Specify)

**Physician** /Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

1 and 2 should be filed wi Health and Mental Hygier Im 27 Is marked other th

Pages 1

Department of Health a Important: If Item 27 Is any Injury or other tra

death with the Maryland

Maryland 21215-0036

Baltimore,

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0 State

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Medical

32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

Registrar

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

or Attending death.

the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Towg, or Location of Death Examiner GEURGES iNEP If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** IONE Months Days Hours Min 1 □ M 2 0 F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits **wode** or other treumatic event, the Madical Examiner must be notified at 1 1 Tes 2 No Completed by Funeral Director or 28a-1 10g. Citizen of What Country? 10e. Street-and Number 10f. Zip Code IASHVI11e 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 [] Yes 2 [] NO If Yes, Give Year or Dates: or Itema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No SIACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during mast of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) VONUE --NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mjddle, Maiden Sumame) Be and Mental H NURENZ AYONIE ပ Mothic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type, Print) nt of Health a SATU KAM RANA 2/1/18 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or and E heverly MD 4 □ Donation 5 🖾 Other (Specify) HOSP. Dis Posa 21. Signature of Funeral Service License 22. Name and Address of Facility 3001 HOSP. DR Prince Georges Hos heverli 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arm shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** isomu /Medical Due to (or as a consequence of): Examiner occupantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this activity and a second and a second and a second and a second and a second and a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a second a seco use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 1 🗌 Yes 2 No Certification: To 1 Ampatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) se ins 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

		4	State of Maryland / Department of Health and    State   Certificate of Death	l Men		211	0.5	26480
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Fune	ral		Montgomery General Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months Days Hours Min	rs. 8. [	Date of Birth Month, Day,		9 Birthn	lace (State or Foreign
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and 2 st and 2 st ealth and n 27 is n			Shirley Browner, Wife 1609 Crestline Road, S					0904
ages 1 nt of H	5		20a. Method of Disposition  1 ☐ Burial 2 [ACremation 3 ☐ Removal from State]  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		0c. Location	-	
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12			X /09 MD D006803					, 2009
3)			30. Name and address of person who completed cadse of death (Item 23a) (Type, Print) Padmaja Bandi, M.D., 18101 Prince Philip Dr., #315, (	01 ne	y, MD	2083	2	
Rec	Stat gistra		31. Date filed (Month, Day, Year)  AUG 0 5 2009  Seneral Signature  August 1. Spaces					

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icia		1. Decedent's Name (First, Middle, Last)  Nettie Mae Banks						Date of Death Month ugust ]	Day Ye	3. Time of Deal 10:50 a
	al er	4a. Facility Name (If not institution, give street and Renaissance Gardens at Ride		kale	4b. City, Town, or		of Death		4c. County of C	Death George's
		5. Social Security Number 6. Sex 1 □ M 2 1 1 M 2 1 1 M 2 1 1 1 M 2 1 1 1 M 2 1 1 1 1	7. Age (In yrs. I		If Under 1 Year Months Days			Date of Birth (Month, Day, une 6,		Birthplace (State or For Country) Alabama
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	ctor	Maryland Montgomery		Silve:	Spring					1 □ Yes 2
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	mo	Elementary/Secondary (0-12) Colleg 5	e (1-4or 5+) +		idance Co			r	O.C. Publ	lic Schools
ı	To Be C	17. Father's Name (First, Middle, Last) Alvis L. Nash					ner's Name <i>(F</i>		laiden Surname)	
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		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. P	emetery, crer Lingto	sition (Name of natory or other place n Nationa etery	il l	Aug 20		Oc. Location - Cit	y or Town, State
ļ		21. Signature of Funeral Service Livensee		F	Name and Addre		ins F	uneral	Home Ind	
ai er	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events	to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or acceptance to (or accep	uence of):						
	Physician/Medi	in the past 12 months?	outcome of pregna ve birth 2 ☐ Fetal regnant at time of d nknown	death 3	Ectopic pregnand Other (specify)	çy			23d. Date o Month	
		Part II. Other significant conditions contributing t Renal Insufficiency	o death but not resu	ılting in the u	nderlying cause giv	en in Part	1.			ite to the caus <i>e</i> of death ☐ Probably 4 ☐ Unkn
	Completed by							24a. Was ar autopsy perform	ned?   dea	re autopsy findings avail r to completion of cause th?  Yes 2  No
	Be	25. Was case referred to medical examiner?  1   Hospital:			oth			Check only one		
	Certification: To	27. Manner of Death 28a. D.	☐ Inpatient 2 ☐ ate of Injury fonth, Day, Year)	ER/Outpatier 28b. Time o Injury	28c. Injui	4.3.	286		nce 6 Other (w injury occurred	(Specify)
	Certifica	3 Suicide 6 Could not be 28e. Pl	ace of Injury - At ho illding, etc. (Specify	ome, farm, str	eet, factory, office		28	f. Location (Str City or Town	reet and Number o , State)	or Rural Route Number,
	Medical (	29a. Certifier (Check only one)  1 ☑ CertifyIng Physician: To 2 ☐ Medical Examiner: On the and n	the best of my kno e basis of examina nanner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my o	me, date a	and place, an	d due to the ca at the time, da	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	ź	29b. Signature and title of certifier	1		29c. Licens		6716		od. Date signed (A August 3	
		Il acoustic.								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 2, Day 2009 Year **Physician** 8:08 a Stephen Andres Brewer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 6905 Horizon Terrace Derwood Montgomery 8. Date of Birth (Month, Day, Year April 12, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Maryland 215-75-8416 2006 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b County 10c City Town or Location 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner and by retified at 1 ☐ Yes 2X No Director Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6905 Horizon Terrace 20855 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Guatemalan Specify: Mutli-Racial 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Athos K. Brewer Helen Castellanos ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen C. Brewer/Mother 6905 Horizon Terrace, Derwood, MD 20855 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 2009 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Runeral Service Licensee Francis J. Collins Funeral 500 University Blvd. W., S Home Inc. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GM1 Gangliosidosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsv certificate 1 ☐ Yes 2 □No 1 □ Yes or Attending Physician: after death. director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2XT No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 00064340 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18506 Office Park Drive, Montgomery Village, MD 20886 Stephanie Hart, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 05 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . 2<u>009</u> **Physician** 7:40 AM Irving Alonzo Bowen August 1, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hollywood 24323 Mervell Dean Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□ F 76 December 25,1932 Maryland 220-28-7174 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in affect to a notified a gone. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director St. Mary's Hollywood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20636 USA 24323 Mervell Dean Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Splicing Foreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leland Stephen Bowen Mildred Catterton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24323 Mervell Dean Road Hollywood, MD 20636 LaRue Bowen / Wife altimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hollywood, Maryland Joy Chapel Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P
P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician acremo disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No icate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Math 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Secrifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

30. Name and address of person

James C. Boyd, M.D.

4/1680 Bessie Drive Ste. 301 Leonardtown, MD 20650 egistrar's Signa

who completed cause

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** 1:20 p 2009 Robert Doyle Buckner August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Lexington Park 49241 Demko Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours DKTKM 2□ F North Carolina 04/10/1929 80 **Director** 246-36-6570 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County d other than "natural", or items 23a or 28a-f show event, the Wedical Evanturer must be notified at 1 □Yes 2X No Director St. Mary's Lexington Park <u>Maryland</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20653 USA 49241 Demko Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify: 2 3₺ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Aircraft Electrician U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of 011ie Mae Fox Aubrey Watson Buckner ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Mark R. Buckner/Son 49241 Demko Road, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 08/05/2009 | Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 22. Name and Address of Facility Brinsfield Funeral Home, P.A. dward w. brinstield. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) nearo **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 1 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check o ne) Be examiner? Other: 4 \( \text{Nursing Home} \) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, Division of Vital Records, P.O.

filed within 72 hours after death

pe

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Domie W Howell

5

29d. Date signed (Month, Day, Year) 29c. License number

22576 MacArthur Blvd., California, MD 20619

31. Date filed (Month, Day, Year) State AUG Registrar

29a. Certifier

(Check only one)

Medical

Registrar's Signature 32

MJ

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

			State of Maryland / Depa State Cert	rtment of Health and N tificate of Death		ene g. No.2009 26485
	Physicia		1. Decedent's Name (First, Middle, Last)  RETHA BERRYMAN		2. Date of Death Month July	3 <sup>Day</sup> 2009 9:20 p M
14	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
^			1007 Kennebec St. #1C  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Oxon Hill If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince Georges  9. Birthplace (State or Foreign
	Funeral Director		577-32-2188 1 M 2 AF 85 Yrs.	Months Days Hours Min.	Sept 6	9. Birthplace (State or Foreign Country) N.C.
	w w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	Maryta -f sho	tor	MD Prince Georges Oxon Hill			1 ☐Yes 2X No
	n the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	23a c	ral	1007 Kennebec St. #1C	20745		USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hydiene. Important: If time 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Erain increment to neithed at once.	by Funeral	1 Never Married 2 Married 1 TYes 2 XINo	/as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐Yes 2☑No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
9-0	2 hour	ted	15. Decedent's Education 16a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentian 15a. Decedentia	ent's Usual Occupation		6b. Kind of Business/Industry
Maryland 21215-0036	ithin 7 ne. han "n	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work O NOT use retired)	ang	CCA
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lary	2 shou and N Is mai	_		g Address (Street and Number or Rui		
<u>≥</u> ໜ້	and health			Kennebec St. #1C		11, Md. 20745
mor	Pages 1 lent of H nt: If ite ry or ot		20a. Method of Disposition  1 □ Burial 2 ☐ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, crem  Metropoli	tan Crematory 8-4		0c. Location - City or Town, State  Alexandria, Va.
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee	Name and Address of Facility arshall s Funeral	Home of	
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.			st, Approximate Interval Between
Sing.	Physician		Immediate Cause (Final disease or condition Adult Failure to	Thrive		Onset and Death
1	/Medical Examiner		Due to (or as a consequence of):	Termula d d Tarricomd		
		Jer	Sequentially list conditions, in any, regaining to immediate b. Senile Dementia, Due to (or as a consequence of).	Lymphold Leukemi	a	
	ecuted ind transit	Examiner	i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
8760,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):			
687	ificate g phys is the	edical	d			
Box	eath certific attending p for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery
О.	the dea / the at ched fo	Physician/Me		Other (specify)		Month Day Year
ሌ σ.	ires that the de signed by the I be detached I	by Ph	Part II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ord	w require s been sig should b	ted k			1 🗆 Yes	s 2∑ No 3 Probably 4 Unknown
l Records,	The la ate has sage 2	Completed			24a. Was an autopsy perform 1 □ Yes 2	prior to completion of cause of
Vita	siclan: The certificate h rector, page	Be (	25. Was case referred to medical examiner?		th (Check only one	
ot	Physic rthis craldin	₽.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	,	ome 5 🖾 Resider 28d. Describe hov	nce 6 Other (Specify)
o	nding Phath.	ation	1 ☑Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Zuu. Describe not	v injury occurred
Division of	Hospital or Attend 4 hours after death Funeral Director: /	Certification: To	3 ☐ Sulcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
Λ	_ 0 _ 0	Medical (	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death 2  Medical Examiner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
4	To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
	11		U rotus 00	1466665	0	8 100/ 2009
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, P	if Ct. Ste 700	LArgo	MD2077K
	Sta Registra	te ar	31. Date filed (Month, Day, Year)  AUG 0 5 2009  32. Registrar's gnature	•	J	•

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1,\_ 7:57 P M 2009 Brown August Jeannette Rogers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda 5908 Searl Terrace If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛛 F Jan 31, Texas 1920 89 Director 452-24-9313 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h County 10a State 28a-f show Exerciner must be notified at 1 □Yes 2 No Director Bethesda MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 20816 5908 Searl Terrace 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 6 Specify. Specify: White ъ М 3XXVidowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Janak August Rogers ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 203 Falcon Ridge Rd. Great Falls, VA 22066 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Leland S. Brown III/son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 08/05/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service L 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final vears Physician Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of the cause of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death.

To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day Month in the past 12 months?
1 ☐ Yes 2 💆 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 ☐ Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co Mb cery amil 30. Name and a dress of person who completed of use of death (Item 23a) (Type, Print) Daniel V. Young, M.D. 4530 Connecticut Ave. NW Suite 104 Washington, D.C. 20008 AUG 0 5 2009 31. Date filed (Month, State park Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year Day Month 649 AM Mack Allen Dowen 2009 Hugus+ 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death alvert Hospital Memorial Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 4 1957 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Days Months Hours 1 → M 2 □ F 51 Ohio 214-78-7125 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Calvert St. Leonard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1449 Plateau Road 20685 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sheet metal worker construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Wilson Bowen Ruth Fertig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Bowen-wife P.O. Box 114 St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug 7 2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Port Republic Maryland Chesapeake Highlands Mem. Gardens 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee BRausd 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embolism Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 (No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury

**Examiner** Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. Intent of Heath and Mental Hyglene. That "I fem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at

Department of Health and Mental F Important: If item 27 is marked ot any injury or other traumatic ever once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran Physician/Medical After this certificate has been signed by funeral director, page 2 should be detact Completed by Be Medical Certification: To 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

2 was State Registrar

Hospital Road Hepp MD 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

29c. License number

167594

Frederick

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 3, 2009

20678

			Please Type or Prin				-	_	
			1 - State of Ma	aryland / Dep <i>Ce</i>	ertificate of		-	giene Reg. No. 2005	26488
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Charles Leroy Burk, Jr.				2. Date of De Month	Day 200	3. Time of Death  9 6:56 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital		4b. City, Town, o	or Location of Death		4c. County of Dea	
_	Funeral		5. Social Security Number 6. Sex 7. Ago	e (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		rthplace (State or Foreign
	Director		193-44-5293 1 <sup>™</sup> M 2 F Usual Residence of Decedent	54 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Date 12/24/1	1954	PA
	arylan show	Ž	10a. State 10b. County	10c. City, Town or L		ř			10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	the M	Director	PA Mercer  10e. Street and Number	E. Lacka	wannock 1	wp.		10g. Citizen of What C	
	th with	al Di	673 Pulaski Mercer Road		16137	7		USA	
	tems	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spo ean, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh	
036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show	by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10	1 ☐ Yes 2 🔀 No	Specify:		Specify:	white
9500-5121	hin 72 ho e. an "natur Madical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occu e kind of work done	during most of worki	ing	16b. Kind of Business	s/Industry
717	withir iene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5	+)	DO NOT use retire	,		Mfg. Railr	oad Cars
and	be filed valued Hygined Property III	Be C	17. Father's Name (First, Middle, Last)					, Maiden Surname)	
$\geq$		오	Charle Leroy Burk, Sr.			Delores			
2	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Susan C. Burk					per, City or Town, State, cer, PA 161	
saltimore,	es 1 au of Hea fitem rothe		20a. Method of Disposition 1 ፟፟ Burial 2 ☐ Cremation 3 ☐ Removal from State		osition (Name of ematory or other pla		Date	20c. Location - City o	
Ĕ	t. Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		Cemetery		/2009	Findley T	
g	permit. Pages 'Department of Important: If ite any injury or of once.		21. Signature of Fundal Service Licensee			iam St., B		Funeral Hom MD 21811	ie
			23a. Part 1. Enter the clsease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not er					Approximate Interval Between
٠.	Physician		Immediate Cause (Final disease or condition		EART	FAILURE		4	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as	a consequence of):					
H	ב ס	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	a consequence of):			-		
	executed in and ial-transit	Examiner	that initiated events C.	a consequence of):					
20/	bur bur		d	,					
X 08/	certificate nding phys ise as the	Medi	IF FEMALE:						
ă	000	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1	2 Fetal death 3	☐ Ectopic pregnan ☐ Other (specify) _	cy		23d. Date of d Month	elivery Day Ye ar
ς, Γ	w requires that the d s been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but	ut not resulting in the u	underlying cause gi	ven in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
ecords	equire een sig ould b	ted b	TREMAKER, LONG	CARNIAC	HY, SIE	VI	1 🗆 '	Yes 2 □ No 3 □ I	Probably 4 Unknown
Hec	The law requires that the ate has been signed by the page 2 should be detached.	Completed					24a. Was autor perfo 1 □ Yes		
VITA	iclan: certific ector,	Be (	25. Was case referred to medical examiner?  Hospital:		Ott	26. Place of Death	h <i>(Che</i> ck o <i>nly</i> c	one)	
5	Phys er this eral dir	To	27. Manner of Death 28a. Date of Inju	ry 28b. Time	SIIL 3 LI DOA			idence 6 Other (Sp	ecify)
vision	auth. r: Afte	ation	1 Natural 5 Pending (Month, Day 2 Accident Investigation	r, Year) Injury		rk? ]Yes 2□No			
	al or Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injubuilding, etc	rry - At home, farm, st c. (Specify)	treet, factory, office		28f. Location ( City or To	Street and Number or F wn, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 butus after death.  To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2 s	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination and/or l	ath occurred at the t investigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
	To the	M	29b. Signature and title of certifier	n d	29c. Licen			29d. Date signed (Mor	nth, Day, Year)
•	_		30. Name and address of person who completed cause of d	eath (Item 23a) (Type	, Print)	06241		0-7-09	
	ET 5		DROTHY C. HOLZMO	RTH M ar's Signature	1.).	263 546	W SI	SUN HILL	Ma, 2/83
	Sta Registr		31. Date filed (Month Day Year) 6 2009 32. Begistra	ar s Signaturey	gares			,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8 **Physician** 2009 3:50 PM Janet Louise Berkov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 8/10/1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 82 156-20-7909 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Marical Exeminer must be notified at 1 ☐ Yes 2 X No Funeral Director Worcester Ocean Pines 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 USA 18 Battersea Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married DOB: 8\10 \26 DOD: 815109 ■ Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by Specify: 3 X Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Rishell Nevin Jennings Smith ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra 112 Hilltop Dr., Severna Park, MD 21146 Ellen E. Berkov / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/6/2009 Frankford DE Cape Henlopen Crem. 5 Cher (Specify) 4 ☐ Dopation 22. Name and Address of Facility Burbage Funeral Home 21. Siac tur 108 William St., Berlin, MD 21811 Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ostrafum **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) n signed by the aid be detached for 1 □Yes 2 🗹 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☑ No 1 □ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this the funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 053612 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthnay Bai

State
Registrar

32. Registrar's Signature

0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended item State of Maryland / Department of Health and Mental Hygiene 23a Part 1, line, C, 8/5/2009, per physcian, 1 - State WCHD, E.T Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:46 M Geneva P. Bumgardner 2 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SAUSBURY WICOMICO DASTAU HOSPICE AT The LAKE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/23/1907 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2)(□ F 101 231-14-9986 ۷A Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23 or 28a-f show any Injury or other traumatic event, Itm Medical Examinating an opice. 1 ☑ Yes 2 ☐ No Funeral Director Worcester Ocean City 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 301 14th St. 21842 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Baltimore, Maryland 21215-0036 Specify: ģ 3 XWidowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Purchasing Agent US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louetta Pence Wade Pence ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty L. Ignash / daug<u>hter</u> 301 14th St., Ocean City, MD 21842 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Gardens Cem 8/6/2009 Arlington, VA 22. Name and Address of Facility Burbage Funeral Home 21. Signature Funeral Service 108 William St., Berlin, MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RRNAL Physician CHRONIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Chronic Kidney Disease III and burial-trai be exect Due to (or as a consequence of): Box 68760, Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 € No 5 ☐ Other (specify) P.0. 9 Unknown ò signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2/ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s perform 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICA 1 Yes 2 AND 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 12 Natural 2 ☐ Accident 28b. Time of Injury 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t After t 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACGBURY WARY GHUWAN State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:30 aM 2009 02 Harold Briefel August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠** M 2□ F Director New Jersey 142-16-0789 84 January 05, 1925 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination and the continuation. 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1218 Downs Drive U.S.A. 20904 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Marketing Fairchild Industries 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Jules Briefel Gussie Jacobowitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Briefel - Wife 1218 Downs Drive, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Buriat 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 08/03/2009 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. rep 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Pleural Effusion disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pleurodesis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Lung Cancer burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Coronary Artery Disease IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Acute Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an rector, page 2 s Dehydration autopsy 2 X No 1 ☐ Yes this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60826 August 2, 2009

Registrar
DHMH 17 Rev 1/2001

State

Kshama Garg, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 03

			For State Registrar		State of M	laryland /	-	artment of I <i>rtificate of</i>		and Men		eg. No.	nic	051,92
	Physicia	an	1. Decedent's Name	(First, Middle, La		Pindomo	_			- 1	Date of Death Month <b>ugust</b>	Day	Year <b>2009</b>	3. Time of Death <b>7:25 a</b> M
w	/Medic		4a Facility Name (If	not institution, aix	Alice R.	Bindema	11	4b. City, Town, o	or Location o		ugust	1	unty of Death	1
	Examin	er	, ,	ıburban Hos		,		,	Bethesd	la			Montg	omery
	Funeral		5. Social Security No	umber 6. S	Sex 7. A	ge (In yrs. last b	irthday)	If Under 1 Year Months Days		24 Hrs. 8. [ Min. (	Date of Birth Month, Day,	Year)	9. Birth	place (State or Foreign
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	28a-	Director	Maryland  10e. Street and Nun		somery			10f. Zip Code	Dethebe		11	0g. Citizen	of What Cou	intry?
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	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heatht and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Everther must be notified at	Funeral	11. Marital Status	CULTUITIE	12. Was Deceden Armed Forces		13.	Was Decedent of If Yes, specify Cut		gin? (Specify	Yes or No-		Race - Amer Black, White,	ican Indian,
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lan	should be nd Mental marked o	70 B		Samue1	Rosenberg						Evel	yn Sei	der	
Maryland	should and Mer Is marke aumatic	-	19a. Informant's Na	me/Relationship	(Type. Print)	11	9b. Maili	ng Address (Stree	t and Numbe	er or Rural Ro	ute Number	, City or To	wn, State, Z	ip Code)
	and 2 salth n 27 I		Jody Bi	ndeman - Da	aughter		71.	7 Edelblut	Drive,					
altimore,	ges 1 it of H if item or oth		20a. Method of Disp		Removal from State	ceme	of Dispo tery, cre	osition (Name of matory or other pla	ace)	Date		20c. Locat	ion - City or T	own, State
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Ball	permit. Pa Departmer Important: any Injury once.		21. Signature of Fu	neral Service Lice	nsee Dam	rell	1	2. Name and Addr Hines-Rinal L1800 New H	di Fune	ral Home	e, Inc. e, Silv	er Spr	ing, Mar	ryland 20904
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Box	eath certifi attending for use as	Physician/M	23b. Was decedent in the past 12	months?		e of pregnancy 2 ☐ Fetal dea t at time of death		☐ Ectopic pregnar ☐ Other (specify)	псу			230	d. Date of deli Month	Day Year
o.	the de	ysic	1 □Yes 2 b 9 □ Unknown		9 Unknown			Other (apecity)						
σ.	that the de		Part II. Other signif	icant conditions	contributing to death	but not resulting	j in the ι	underlying cause g	jiven in Part I		23e. Did to	bacco use	contribute to	the cause of death?
rds	uires n sign lld be	d by	Pneumon	ia							1 <b>k</b> Ye	es 2 🗆 l	No 3□ Pr	obably 4 🗌 Unknown
of Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed									24a. Was a		24b. Were au	topsy findings available
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sio	ttendi death. tor: / the fu	cati	2 ☐ Accident 3 ☐ Sulcide	investigation 6 Could not	ho l		f==== at	-	□Yes 2□	-	Lagatian (C		tumber or D	und Davita Number
Division	i. ∰ # o	Certification: To	4 ☐ Homicide	determine		etc. (Specify)	iarrii, Si	treet, factory, office		201.	City or Tow	n, State)	vumber or no	ıral Route Number,
	ospital or hours afte uneral Dir		29a. Certifier	<b>1</b> Certifvina F	Physician: To the be	st of my knowle	dge, dea	th occurred at the	time, date a	nd place, and	due to the	cause(s) a	nd manner as	s stated.
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	To the within somple comple	Me	29b. Signature and	title of certifier					nse number		2	,	signed (Monti	h, Day, Year)
	*		1 Au	W	SUDAR	SHAN SI	rn	D	65312			81	5/09	
	$ \wedge $		30. Name and add	ess of person who	completed cause o	f death (Item 23	a) (Type	, Print)						
			Sudarsha	n Siva, M.	D., 8600 010	l Georget	own R	oad, Bethe	sda, Ma	ryland 2	0814			
	Sta		31. Date filed (Mon	th, Day, Year)	32 Aegi	strar's Signature	1	arks.						
	Regist	reli'		IUU II 4	LUUJ COU	-	6							

DHMH 17 Rev 1/2001

			State Registrar	tate of Maryland	•	tificate of		F	leg. No. 2009	26493
	Physici	an	1. Decedent's Name (First, Middle, Last)  Ruth Audrey Berry					2. Date of Dea Month	/28/2009 <sup>Year</sup>	3. Time of Death 11:40 pm
, jung	/Medic		4a. Facility Name (If not institution, give stre	et and number)		4b. City. Town, or	r Location of Death	L	4c. County of Deat	
	Examir	lei	Solomons Nursing C			Solomo			Calvert	
I	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pa) 09/30/1	921 9. Birth	hplace (State or Foreign uptry)
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loc	eation				10d. Inside City Limits
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	the N 28a- notifi	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	3a or		15503 Letcher R	oad E.		20	0613		United S	tates
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Moderal Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H FYes, specify Cuba □Yes 21X111100000000000000000000000000000000	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian, e, etc. White
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	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retired nemaker	during most of work d)	3	Own Hom	e
2	filed within Hygiene. other than "		17. Father's Name (First, Middle, Last)				18 Mother's Nam	ne (First, Middle,	Maiden Surname)	
auc	d be f ental l ced of	o Be	Aubrey H. Og	den			E1si	e R.	McCulley	
Maryland	nd 2 should be filed within Ith and Mental Hygiene. 27 Is marked other than ' traumatic event, the Mark	70	19a. Informant's Name/Relationship (Type. Betty Helms (I		19b. Mailin	g Address (Street Pelagio	and Number or Ru C Lane,	ral Route Numbe	n, City or Town, State, 7	Zip Code) 1688
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  M∑Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	20b. Pla cei		sition (Name of natory or other play		Date 2009	20c. Location - City or Suitland	
Baltir	permit. F Departm Importar any injur		21. Signature of Funer   Sprive   Icon	L masses	22		$^{ ext{ess of Facility}}  ext{Le} \epsilon$		al Home, , Clintor	Inc 6633 (
	_		232. Part1. Enter the disease, or complicat	ions that caused the death.						Approximate Interval Between
-	Physician /Medical	ii A	Shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		is R	ghe	Fore	-	Onset and Death
	sician and sician and surial-transit	al Examiner	Sequentially list conditions, if any see fing 1. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moords? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnan  1 ☐ Live birth 2 ☐ Fetal  4 ☐ Pregnant at time of de  9 ☐ Unknown	death 3.□	Ectopic pregnand Other (specify)	су	- W 1 10 C W 1 -	23d. Date of de Month	livery Day Year
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of Vital Records,	n: The law rei ficate has bee or, page 2 sho	Completed by	Peripheral A THERO SCIERE  25. Was case referred to medical	TIC HE	ART	Dis		1 □Yes	sy prior to death? 2 □ NO 1 □ Yes	utopsy findings available completion of cause of
5	rsicia s cert lirecto	o Be	examiner?	pital: 1 ☐ Inpatient 2 ☐ E	B/Outpatier	ot 3 DOA Oth	26. Place of Dea		dence 6 Other (Spe	ncifu)
1 Of	g Phy erthi eral c	n: To	27. Manner 1 Death	28a. Date of Injury	28b. Time of				now injury occurred	
Division	or Attending fter death. Jirector: Aft in by the fun	Certification:	1	(Month, Day, Year)  28e. Place of Injury - At hor building, etc. (Specify,		M 1 □	lk? ]Yes 2□No	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	Hospital 24 hours a Funeral I etely filled	Medical Ce		ian: To the best of my know : On the basis of examinati and manner stated.						
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mon.	th, Day, Year)
	0		30. Name and address of person who comp	pleted cause of death (Item	23a) (Type,					
1	RCK		ANWAR MUNSHI	SUITE 300	130	HOSPITA	C RD. 1	PR. FRE	DEKICK M	1 20678
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ire A. Z	backer			DERICK M	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1:53 p <sup>M</sup> July 31 2009 <u>Bradley Lee Baker, Sr</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □ F Director 30 1936 NC Mar <u>244-50-1720</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Carroll Taneytown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4673 Babylon Road 21787 USA death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐ Yes 2 ∐XNo Specify Specify: 9 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) C.J. Miller 10 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Perry John Morgan Baker ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Mary Baker/wife 4673 Babylon Road Taneytown, MD Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Lakeview Memorial Pk 8/04/2009 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of : Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes 2X No 1 ☐ Yes after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1. 105Pice Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Certification: 28d. Describe how injury occurred al or Attending Is after death. Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled in 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on one) To the within 2

NJL 5

29b. Signatu

Name and address of person who

Registrar

State

31. Date filed (Month, Day, AUG 04

ENTER STREET WESTYNUSTER, MI) 21157

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 21000 **Physician** Addus 10 MYRIDRIC /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Mar.27, Director 218-28-6129 76 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show notified at 1X Yes 2 □ No Director Maryland Baltimore City 10g. Citizen of What Country? 10e. Street and Numbe South ь pe 23a must h 717 Ann Street 21231 <u>U.S.A.</u> Funeral ural", or items 2 Examiner mus Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after ual Hygiene. In ether than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 24 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Management Development College (1-4 or 5+) Elementary/Secondary (0-12) 12 5± Consultant Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be a nent of Health and Mental B if Health and Menta Benjamin Blank Bessie Schrieber Blank ည other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South 19a. Informant's Name/Relationship (Type. Print) Myrna Poirier/spouse Ann Street, Baltimore City, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place Little Piney Branc Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h Important: If ite any Injury or ot 1 XBurial 2 Cremation 3 Removal from State Little Branch 4 Donation 5 Other (Specify) Aug. 14, 2009 Denton, Maryland 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA 21. Signature of Funeral Service Licensee the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx Approximate Interval Between Onset and Death 23a Part 1 shock, or heart failure. List only one cause on each line. 1mmediate Cause (Final Infiltrative Cardiomyopathi **Physician** disease or condition /Medical resulting in death) **Examiner** Amyloidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760. physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy detached for u Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has b director, page 2 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 🗹 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: s after death.

I Director: After to the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) In 24 hours, or the Funeral D' completely fille 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre ICKRAM AS INGHE 600 North Wolfe St, Baltimore, MD, 21287

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Req

AND 12 9008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06328 State of Maryland / Department of Health and Mental Hygiene Thomas Borum, III Certificate of Death 1- For State Rea. No Registrar 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 13, 2009 0138 hrs Medical Examiner Thomas Raymond BORUM, III c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country' Months Days Hours Oct. 6, 1978 Maryland Director 30 214-08-7962 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Inh County 1 Yes 2 X No 28a-f show Maryland Washington Hagerstown yes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 USA 11725 Oriole Drive 23a Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes white Specify f Yes, Give Yea Yes 2 X No specify: Widowed Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) than truck mfg. 12 assembly technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas R. Borum Jr. Charlotte Belloff Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) B 260 Potomac Heights, Hagerstown, Maryland 21742 Thomas R. Borum Jr. - father If item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition ltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8/17/09 Hagerstown, Maryland Important: Rest Haven Cemetery Donation 5 Other Specify 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 21740 415 E. Wilson Blvd., Hagerstown, Md. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Heroin intoxication Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury mat initiated events resulting in death) Last Due to (or as a consequence of): and transit AMENDED #1 as noted, 23a,27,28a-f,perME, g894 8/26/09 TT Physician/Medical X UNPENDED the attending physician ed for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, s been s 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? certificate has performed? ✓ Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Be Other 4 examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 Innatient 2 V ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury Natural Yes 2X No Fd 10:40 Pending Fd 8/12/09 Director: the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11725 Orcal Dr in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide residence determined (Specify) Hagerstown, MD Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital To the

> Melissa Brassell, MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 13, 2009

Kamera

ALL

29b. Signature and title of certifier

29a. Certifier (Check only 1 one) 2

Medical

State

Registrar

		For State Registrar			•	rtment of h			Reg. No	(1173 E) (N	2.	1497
Physician /Medical		1. Decedent's Name (First, Middle, L		CE BROWN			2. Date of Death Month Day Year 3. Time of Death August. 12. 2009 3. 30 P					
Examin Funeral Director	er	4a. Facility Name (If not institution, g  HARFORD ME  5. Social Security Number 6.  139-05-7868	MORIAL H	6 50 17 e (In yrs. las 90			If Under 24 Hrs Hours Min.	. 8. Date of B	irth H	County of Deat  ANFON  9. Birt  Per	thplace (Sta	ate or Foreig lvani
ryland ihow	_	Usual Residence of Decedent  10a. State 10b. County		,	Town or Loc					_		e City Limits
the Ma 28a-f s notified	Director	MD Cecil  10e. Street and Number			levi	ville 10f. Zip Code			1 ☐ Yes 2 🖾 No			
th with 23a or ust be		56 Bluff Rd.				21919			U.S.A.			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It w Musical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Marrled 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give		l l	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto			s or No- tc.)  14. Race - American Indian, Black, White, etc.  Specify: White			
l within 72 ho giene. r than "natu: ithe Medical	Completed	15. Decedent's (Specify only highest selementary/Secondary (0-12)	Education trade completed) College (1-4or 5 2	i+)	(Give life, L		pation during most of wo d) Enginee			friger	•	n Des
uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Clarence I. Brown				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			t, Middle, Maiden Surname) ry Dunlap			
12 shorth and 17 is ma		19a. Informant's Name/Relationship C. David Brov					and Number or R					2107
Pages 1 and ment of Heali ant: If item 2 ury or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 4 □ Donation 5 □ Other (Spec	☐ Removal from State	20b. Plac	ce of Disponetery, cren	sition (Name of natory or other pla emation	ce)	Date 3/09	20c. L	ocation - City or yrna,	Town, Stat	
permit. Departr Imports any inju	E I	21. Sumptime of Puneral Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Service Servic	M00	0510			ess of Facility Tuneral Cross			tephen a, MD.		
Physician /Medical Examiner	Examiner	23a. Part / Enter the disease, or co shock, or heart failure. List on Immediate Cau le (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ly one cause on each lir	a consequel	nce of):	ar the mode of cyr	ng, 3001 us cardie	a of Tesphalory			Interval Onset a	imate I Between and Death
cate be e ohysician the buria			d									
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Name and address of person with a conditions  21   Medical Examination   1   Certifying   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   Medical Examination   2   M	Hospital: Nature of the basis of and manner sta	2 Fetal d at time of dea  ut not resulti  Let Let Let Let Let Let Let Let Let Let	ing in the un  A C C C C C C C C C C C C C C C C C C	anderlying cause given the factory, office the occurred at the twestigation, in my	ven in Part I.  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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2009 7:45 Miriam Carp August а /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/10/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 217-12-6325 88 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It will claim Examination to a context than the marked and injury or other traumatic event, It will claim the context of the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the context and the 1X Yes 2 □ No Maryland Silver Spring Montgomery 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? CHRM 20906 15107 Interlachen Drive #2-325 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary School Elementary/Secondary (0-12) College (1-4or 5+) Music Education 5+ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Brown Benjamin Kupper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Duke Court, Rockville, Maryland Karen Carp, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/05/2009 Falls Church, Virginia National Crematory 21. Sign rupe of 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Service Licensee MO1255 20852 1091 Rockville Pike, Rockville, Maryland 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed .Multiple Ulcers and Due to (or as a consequence of) physician a Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 5 Other (specify) P.0. the 9 I Inknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medica examiner? director, Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057458

Registrar

31. Date filed (Month, Day, Year)

AUG 05 2009

10

Dr. Pinky Singh, 6502 Kenilworth Avenue, Riverdale, Maryland

30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 1.00 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** William Marvin Cheseldine 4:50 P M August 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 23170 Kitty Ct. St. Mary's Leonardtown 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 11/22/1925 Maryland Director 83 579-34-1179 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination on other traumatic event, the Medical Examination on other traumatic event, the Medical Examination on other traumatic event, the Medical Examination on the natified at once. XXYes 2 ☐ No Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23170 Kitty Ct. 20650 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1**Y**Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **HVAC Technician** Heating & Air Condition 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Francis Cheseldine 2 Laura M. Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Bernice Cheseldine / Wife 23170 Kitty Ct. Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Charles Memorial 08/10/2009 | Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Luns CANCEN MOTATATIC MUNTAS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 

Ectopic pregnancy Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 70 2 🗆 No 1 ☐ Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

David M. Federle, M.D.

31. Date filed (Month, Day, Year) 1 2009

m Juliele MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

24035 Three Notch Road, Hollywood, MD 20636

29d. Date signed (Month, Day, Year)

			State of Maryland / Dep	artment of Health and I <i>rtificate of Death</i>		/1111	25500				
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Dea	Reg. No.	3. Time of Death				
	Physicia		Sidney Neff Clark		Month August	12, 2009	9:50 a M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat					
			22175 Indian Bridge Road	California		St. Mar	y's				
ı	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birtl (Month, Day	h 9. Birt	hplace (State or Foreign untry)				
	Director		229-05-8056 91 Yrs.  Usual Residence of Decedent		03/14/	1918	Virginia				
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits				
a-fsh	Mary a-f sh	ctor	Maryland St. Mary's Cal	ifornia			1 ☐ Yes 2 🔀 No				
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?					
	23a c		22175 Indian Bridge Road	20619		USA					
	tems	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	No-  14. Race - American Indian, Black, White, etc.  Specify:  White					
2	s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 🖫 No If Yes, Give Year or Dates:	1 □Yes 2 <b>x</b> No <i>Specify</i> :							
	thou		15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/Industry					
3	hin 7%	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of wor DO NOT use retired)	king						
7	d with	Completed	8	Machinist		Factory					
2	be file d oth event	Be	17. Father's Name (First, Middle, Last) Oscar Neff Clark	18. Mother's Nam		Maiden Surname)					
7	Mer Marke narke	1º	-				7-0-1-1				
2	d 2 sk th and 7 is n traun			ing Address (Street and Number or Ru		-					
נ	1 an Heal tem 2			75 Indian Bridge I	Date Cal.	20c. Location - City or					
2	ages ent of ht: If i		1X XBURIAL 2 LICREMATION 3 LIBERTOVALITOR STATE I		15/2009	Wytheville	, Virginia				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant har must be neithed at once.			2. Name and Address of Facility B	rinsfield	d Funeral H	ome, P.A.				
ă	Depar Impor any ir		Danielle Ward M01403	22955 Hollywood I	Rd., Leon	nardtown, M	D 20650				
Physician /Medical Examiner			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between				
		Immediate Cause (Final disease or condition Kidney Failure				Onset and Death days					
		resulting in death)  Due to (or as a consequence of):									
	-K	Sequentially list conditions, if any leading to immediate b. Atherosclerosis  Due to (or as a consequence of):			years						
nsit		Examiner	cause. Enter Underlying Cause (Disease or injury								
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Š	cate be executed physician and the burial-transit	dical									
5	ing ph	Med	IF FEMALE:		-		-				
	leath certific attending p	sician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delivery  Month Day Ye					
5	the a	sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Inchian Day You					
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2	uires n sign ld be	d by	Congestive Heart Failure		1 XX	Yes 2 No 3 Probably 4 Unknown					
5	w red s bee	Completed	Chronic Obstructive Pulmonary Di		24a. Was an 24b. Were autopsy findings available						
ב	The la	omp		psy prior to completion of cause of death? 2 No 1 □ Yes 2 □ No							
ā	ian: irtifica stor, p	Be C									
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	To B	examiner?  1   Yes   2   MNo									
	on:	27. Manner of Death 28a. Date of Injury 28b. Time Injury (Month, Day, Year) Injury	Work?	28d. Describe h	now injury occurred						
2	ttend death stor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location /6	Street and Number or Rural Route Number,					
2	after after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	reet, factory, office	City or Tow	Town, State)					
-	splta nours neral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	n 24 l	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	date and place, and due to the cause(s)							
0.0	withi To the	Ž	29b. Signature and title of certifier		. Date signed (Month, Day, Year)						
)	/		· Na allenan	D0055682		8-13	-09				
	2 m		30. Name and address of person who completed cause of death (Item 23a) (Type		1.	MD 20650					
	Sta	to		oakley St., Leona	rdtown,	MD 20650					
	Registr		31. Date filed_(Month, Day, Year)  AUG 13 2009  Server B. Jan	w							

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